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INTAKE FORM

Please fill out completely

Date: _____

Who referred you to this office? _____

Name: _____ **Date of Birth:** _____ **Age:** _____

Address (not a p.o. box): _____

City: _____ **Zip Code:** _____ **County:** _____

Home Telephone Number: (____)_____ **Cell: (____)**_____

Gender: M F Race/Country of Origin: _____ **Marital Status:** _____

Education:

Highest Grade Completed _____

If minor, name of school currently attending: _____

Occupation: _____

Employer: _____ **How long at this employer?** _____

Person Responsible for Bill: _____
Name **Address**

_____
Driver's License # **Social Security #**

_____
Insurance **Policy #/Group #** **Authorization #**

Main reason for seeking psychotherapy at this time:

_____

_____

_____

Persons Currently Living With You:

Name	Age	Relationship to You

Are you court-ordered to participate in counseling? **YES** **NO**

Are you involved in an active CPS case? **YES** **NO**

Do you have any current legal difficulties? **YES** **NO**

If yes, please explain: _____

MEDICAL:

Primary Care Physician: _____ **Telephone:** _(____)_____

Date of Last Physical Examination: _____ **Reason:** _____

Chronic Medical Conditions: _____

Operations, Head Injuries, Medical Illnesses (with dates): _____

_____

Allergies and Drug Reactions: _____

CURRENT MEDICATIONS (including psychotropic medications):

Medication	Dosage	How Long Have You Been Taking?	Reason for Taking This Medication?	Name of Prescribing Physician

PREVIOUS MENTAL HEALTH CARE:

Previous Psychotropic Medications:

Dates	Medication	Problem(s) Addressed	Result

Previous Mental Health Providers (therapists, psychiatrists, school counselors):

Dates	Provider's Name & Tel. #	Problem(s) Addressed	Result

Previous Psychiatric Hospitalizations:

Dates	Hospital/Location	Problem(s) Addressed	Result

FAMILY PSYCHIATRIC HISTORY:

Do you have any relatives that have had serious mental/emotional problems or alcohol/drug problems? If so, please list:

Relationship	Diagnosis	# of Hospitalizations

FAMILY-OF-ORIGIN HISTORY:

Relative	Name	Current Age (or age at death)	Illnesses (or cause of death, if deceased)	Education	Occupation
Father					
Mother					
Stepparents					
Grandparents					
Uncles/Aunts					
Brothers					
Sisters					

EMERGENCY INFORMATION:

If some kind of emergency arises and I cannot reach you directly, or I need to reach someone close to you, whom should I call?

Name: _____ Phone: _(____)_____

Address: _____ City: _____ Zip: _____

Relationship to you: _____

CURRENT PROBLEMS OR SYMPTOMS

- **Headaches**
- **Dizziness**
- **Stomach trouble**
- **Bowel trouble**
- **Back pain**
- **Tremors or tics**
- **Other physical problems**

- **Can't get to sleep**
- **Nightmares**
- **Trouble concentrating**
- **Memory problems**
- **Worry a lot**
- **Can't make decisions**
- **Tense/unable to relax**
- **Panicky feelings**
- **Unreasonable fears**
- **Fear of losing self-control**

- **Strange or unusual thoughts**
- **Hallucinations**
- **Repetitive thoughts/acts**
- **Feel others try to harm you**

- **Ready to explode**
- **Thoughts about harming someone**
- **Excessive use of alcohol/drugs**

- **Wake up at night or in the early morning & unable to return to sleep**
- **Loss of appetite**
- **Weight loss**
- **Unable to enjoy life**
- **Decreased sex drive**
- **Feel worthless**
- **Feel hopeless/helpless**
- **Thoughts of suicide**
- **No energy**
- **Sadness or depression**
- **Have withdrawn from others**

- **Weight gain**

- **Increased sex drive**
- **Increased energy**
- **Decreased need for sleep**

- **Family conflicts**
- **Work problems**
- **Can't make or keep friends**
- **Feel very shy or afraid to stand up for your rights**

- **Other:** _____
  _____
  _____