## INTAKE FORM - CONFIDENTIAL

**Patient Information:** Date:

Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_ First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_ Sex:\_\_\_\_\_\_\_

Mailing Address:

City/State: Zip:

Phone: ( \_\_\_ ) \_\_\_\_ - \_\_\_\_\_ Work Phone: ( \_\_\_ ) \_\_\_\_ - \_\_\_\_\_

**Employer/School Information:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:

Address:

City/State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Education/Degrees:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade:\_\_\_\_\_\_\_\_

**\*In Case of Emergency, Contact:**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical/Mental Health History**

**Primary Care Physician:**

Name of Practice:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Provider Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**All Past Diagnoses** (please give the year):

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications** (include dosage and frequency):

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychiatrist:**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Previous Out/In Patient Therapy** (please specify which):

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Stressors affecting you or your family in the past 1 – 2 years**:

\_\_\_\_\_\_Deaths \_\_\_\_\_\_Job Change/issues \_\_\_\_\_Sexual Abuse

\_\_\_\_\_\_Births \_\_\_\_\_\_School \_\_\_\_\_Broken Relationship

\_\_\_\_\_\_Marriage \_\_\_\_\_\_Step-children \_\_\_\_\_Unwanted Pregnancy

\_\_\_\_\_\_Divorce \_\_\_\_\_\_Separation \_\_\_\_\_Substance Abuse

\_\_\_\_\_\_Moving \_\_\_\_\_\_Physical Abuse \_\_\_\_\_Medical

\_\_\_\_\_\_Chronic Illness \_\_\_\_\_\_Other:

**Presenting Problems/Reason for Visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**