Office Use Only
File Number: _____
Date of Initial Interview:

_____

Location: H M

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PATIENT INTAKE FORM

WHO IS FILLING OUT FORM? (Please check off) Patient _____ Representative of patient _____ Relationship to patient: _____

1. GENERAL REGISTRATION INFORMATION

NAME: _____ DATE OF BIRTH:_____AGE:_____

Male Female TODAY'S DATE: _____ HOW DID YOU HEAR ABOUT MY PRACTICE?

_____

HOW DO YOU THINK I MAY BE OF HELP TO YOU? PLEASE BRIEFLY DESCRIBE YOUR CHIEF CONCERN: _____

_____

HOME ADDRESS:_____

TELEPHONE NUMBERS AND EMAIL: ***Please fill in and then place a checkmark ✓next to the preferred method of being contacted.***

☐ HOME: _____ ☐ BUSINESS _____
☐ CELL: _____ ☐ EMAIL: _____

HIGHEST LEVEL OF EDUCATION ATTAINED:_____OCCUPATION:_____

ETHNIC/RELIGIOUS BACKGROUND (OPTIONAL)**:_____**

WITH WHOM DO YOU LIVE? _____

MARITAL STATUS: _____SINGLE ____MARRIED ____DIVORCED____WIDOWED ____SEPARATED

SEXUAL ORIENTATION (OPTIONAL) :_____

EMERGENCY CONTACT: NAME:_____ RELATIONSHIP:_____

TELEPHONE NUMBER(S)**:_____**

IF YOU HAVE <u>MEDICARE</u>, PLEASE FILL OUT THIS SECTION. IF NOT, SKIP TO SECTION 2.
NAME OF INSURED AS IT APPEARS ON MEDICARE CARD: _____
MEDICARE ID # _____ *PLEASE ATTACH A COPY OF YOUR MEDICARE CARD OR BRING IT TO YOUR FIRST SESSION.*
DO YOU HAVE A SECONDARY INSRURANCE COMPANY THAT PARTICIPATES IN A ***MEDICARE CROSSOVER ARRANGMENT?*** _____ No _____ Yes IF YES, HAVE YOU VERIFIED WITH YOUR INSURERS THAT MEDICARE WILL FORWARD BILLS ELECTRONICALLY TO YOUR SECONDARY INSURER ON YOUR BEHALF? ____ No _____ Yes, on this date: _____

2. HEALTH HISTORY

a) Your mental health care: From where have you received evaluations or care from a *psychiatrist, psychologist, or social worker in an outpatient or inpatient setting*? Please include people you are currently working with. Please also note, these providers will not be contacted without your permission.

Name of Professional and Discipline (e.g., psychologist, psychiatrist, social worker, inpatient facility)	Type of Service (evaluation, therapy, medication management, inpatient care)	Dates of Service Mo/Yr - Mo/Yr	Diagnosis(es) given

Have you ever considered or sought treatment for problems related to any of the following? Check all that apply:

_____ Substance abuse or dependence
_____ Domestic violence
_____ Trauma (e.g. victim of assault, sexual abuse, other crime, accident)
_____ Suicidal thoughts or behavior
_____ Non-suicidal self-injury
_____ Eating disorder

b) Your medical care: From whom or where do you get your medical care?
Clinic/doctor's name: _____ Phone: _____
Address: _____
Date of last exam: _____ (If you enter treatment with me for psychological problems, I may want to tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment, but I will ask for your written authorization first.)

Please list any current or past medical issues, including acute or chronic illnesses, surgeries or injuries: _____

_____

_____

Please list ***all <u>current</u> medications***:

Medication	Daily Dose	What problem is medication treating?

Please list ***all <u>past</u> medications***:

Medication	Dates Taken (Yr-Yr)	What problem was medication treating?

3. EMPLOYMENT AND EDUCATION HISTORY

a) Employment: What is your **current** employment status? _____ Unemployed _____ Employed part-time _____ Employed full-time
Employer: _____ Address: _____
_____
Your position: _____

What is your **past** employment and military experience?

Name of military branch or employer	Dates of Service Mo/Yr - Mo/Yr	Job title or duties	Reason for leaving

b) Education

Please list all the schools you have attended including and starting with any current ones.

Name and type of school (e.g., elementary, junior high, senior high, community college, univ.)	Dates of attendance Mo/Yr - Mo/Yr	Special services or accommodations? (e.g. IEP, speech therapy, OT, PT)	Did you graduate?	Did you leave before completing program of study?

4. FAMILY & RELATIONSHIP HISTORY

a) Family of Origin

Relative	Name	Deceased? If yes, give date	Current age	Level of education	Occupation	Location of current residence
Father						
Mother						
Stepfather						
Stepmother						
Sibling (or step sib.)						
Sibling (or step sib.)						
Sibling (or step sib.)						
Sibling (or step sib.)						
Maternal Grandfather						
Maternal Grandmother						
Paternal Grandfather						
Paternal Grandmother						

Who from the above list is most involved in your day to day life? Add a person here if not mentioned above: _____

Has anyone in your family ever struggled with problems related to any of the following? Check all that apply:

_____ Substance abuse or dependence *Who:* _____
_____ Domestic violence *Who:* _____
_____ Trauma (e.g. victim of assault, sexual abuse, other crime, accident) *Who:* _____
_____ Suicidal thoughts or behavior *Who:* _____
_____ Non-suicidal self-injury *Who*: _____
_____ Eating disorder *Who:* _____

b) Marriages

	Spouse's Name	Was this spouse's first marriage?	Your age at marriage	Are you still married? **Y** or Divorce = **D** Widowed = **W**	Your age when and if marriage ended
First					
Second					
Third					

c) Domestic Partners and Significant Relationships

	Partner's Name	Did you live together?	Your age when relationship began	Are you still married? **Y** or **N** and reason for ending	Your age when and if relationship ended
First					
Second					
Third					

d) Children and Stepchildren Please indicate in the last column whether child is from current relationship **C,** yours from a previous relationship **P,** or is your stepchild **S**

Name	Age	School	Grade	Adjustment problems?	**C**, **P**, or **S**