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New Patient Intake Form

SECTION 1: IDENTIFICATION

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____

Referred by: _____

Preferred Phone Number
_____(Cell / H / W)
OK to leave message? □ yes □ no

Backup Phone Number
_____(Cell / H / W)
OK to leave message? □ yes □ no

Do you want contact via e-mail? □ yes □ no
E-mail Address: _____
*Please note that e-mail correspondence is not considered to be a confidential medium of communication.

Emergency Contact: _____ _____
Name / Relationship Telephone (Cell / H / W)

Person completing this form (if other than patient):_____

SECTION 2: DEMOGRAPHICS

1. What is your age? _____

2. What is your date of birth? _____-_____-_____
(month - day - year)

3. What is your gender? Male Female Other_____

4. What is the highest level of education you attained?
   (1) Elementary school or middle high/junior high school
   (2) Graduated from high school or received G.E.D.
   (3) Received vocational/technical training
   (4) Some college
   (5) Graduated from a 4-year college
   (6) Received a master's or post-graduate degree
   (7) Received a doctoral degree (Ph.D., M.D.)

5. What is your religious/spiritual background, if any? (optional)
   (1) Jewish
   (2) Catholic
   (3) Protestant
   (4) LDS (Mormon)
   (5) Unitarian
   (6) Muslim
   (7) Atheist / Agnostic
   (8) Other (please specify):_____

6. Are you a full-time student: □ Yes □ No Year/Grade in school: _____
   Major (if applicable): _____

7. Are you employed: □ Yes □ No Occupation: _____
   How long in this position? _____ Do you enjoy your work? □ Yes □ No

8. Current Relationship Status: (circle and add date of event where applicable)
   Never Married _____ Married _____ Domestic Partnership _____ Widowed _____
   Divorced _____ Separated _____ Engaged _____ Other _____
   How long together _____
   Relationship Satisfaction (please circle): 1----------2----------3----------4----------5
   Poor Excellent

9. Do you have children? □ Yes □ No How many? ____ Ages: ____ ____ ____ ____

10. Who else lives in the home (family members or others)?

Name	Relationship to you	Age	Date of Birth	Gender

11. Please describe your reasons/goals for requesting services (be as specific as possible):

_____
_____
_____
_____
_____
_____
_____

SECTION 3: MENTAL HEALTH HISTORY

1. Which of the following kinds of psychological/psychiatric services have you received prior to coming here? PLEASE CIRCLE ALL THAT APPLY.
   (1) None (3) Partial care (5) Other 24-hour care
   (2) Outpatient therapy (4) Inpatient care

For each of the psychological/psychiatric services you indicated, please list the beginning and ending dates you received that treatment:

_____
_____
_____
_____

2. How many times have you received psychological/psychiatric services prior to coming here?
   (1) None (2) 1 – 2 (3) 3 – 4 (4) 5 or more, but fewer than 10 (5) 10 or more

3. Have you experienced any of the following problems? PLEASE CIRCLE ALL THAT APPLY.

(1) Anxiety
(2) Depression
(3) Extreme mood swings
(4) Alcohol or drug abuse
(5) Unusual thought or beliefs
(6) Learning disability
(7) Self-inflicted pain or injury
(8) Social isolation
(9) No appetite
(10) Always tired
(11) Unable to relax
(12) Recurrent dreams
(13) Hallucinations
(14) Feel tense
(15) Fears and phobias
(16) Suicidal ideas
(17) Can't make friends
(18) Poor living conditions
(19) Always worried about something
(20) Can't make decisions
(21) Financial problems
(22) Job problems
(23) Other _____
(24) Victim of abuse
(25) Eating disorder
(26) Criminal behavior/incarceration
(27) Aggression/violence
(28) Overwhelming crisis
(29) Recurrent conflicts with others
(30) Sexual problems
(31) Anger/Hostility
(32) Over-eating
(33) Always sleepy
(34) Insomnia
(35) Nightmares
(36) Inferiority feelings
(37) Feel panicky
(38) Obsessions
(39) Shy with people
(40) Afraid of people
(41) Unable to have a good time
(42) Don't like weekends/vacations
(43) Over-ambitious
(44) Gambling
(45) Can't keep a job

4. Have you ever engaged in self-injurious behavior? Yes ☐ No ☐
   If so, what?_____ If so, when and how often?_____

5. If you have ever attempted suicide, when did your most recent attempt occur?
   (1) I have never attempted suicide
   (2) Within the last month
   (3) More than 1 month ago, but within the last year
   (4) More than 1 year ago, but less than 5 years ago
   (5) More than 5 years ago

6. Has any other member of your family previously sought or received psychological or psychiatric counseling? Yes ☐ No ☐

7. Please circle below items if a family member has a current diagnosis, history, or if there is a family history of any of the following conditions. List family member affected, (father, mother, brother, sister, grandparent, uncle, aunt etc.).

_____ Family Member _____
Alcohol/Substance Abuse/Dependence_____
Anxiety_____
Depression_____
Domestic Violence_____
Eating Disorder_____
Obsessive Compulsive Disorder_____
Schizophrenia_____
Bipolar Disorder_____
Suicide Attempts_____
ADHD_____
Other_____

8. Do you currently or have you ever used illegal drugs or misuse(d) prescription medications?
   Yes ☐ No ☐
   If yes, please state when, how much, and if you have received treatment:

_____
_____
_____
_____

SECTION 4: MEDICAL HISTORY

1. Have you had a physical examination within the last six months? Yes ☐ No ☐

2. Have you seen a physician or other health care professional within the last six months for reasons other than a physical checkup? Yes ☐ No ☐

If yes, please specify reason(s): _____
_____

3. Please circle any of the following that you have experienced either currently or in the past:

(1) Headaches
(2) Dizziness
(3) Fainting spells/blackouts
(4) Severe or prolonged nausea
(5) Seizures or convulsions
(6) Memory loss
(7) Allergies
(8) Asthma
(9) Ulcers
(10) High blood pressure
(11) Thyroid difficulties
(12) Diabetes
(13) Hypoglycemia (low blood sugar)
(14) Heart disease
(15) Other heart condition (e.g., heart murmur, mitral valve prolapse
(16) Gastrointestinal issues (specify):_____

4. How many serious injuries (that needed medical attention) have you had?
_____
_____
_____

5. How many surgeries have you had? _____

6. Please describe major illnesses, surgeries and/or serious injuries and dates:
_____
_____
_____

7. Are you currently taking prescription medications? Yes ☐ No ☐ If yes, please list:

Medication	Dose	Reason for taking

8. List any over the counter medications you currently take, including vitamins/supplements:

Over The Counter Vitamin/Supplement/Medicine	Dose	Reason for taking

9. Do you currently, or have a history of using substances/alcohol? Yes ☐ No ☐ If yes, list:

Substance / Alcohol	How much in one sitting?	How often per day, week or month?

10. Have there been changes in your sleeping patterns in the past three months? Yes ☐ No ☐
If yes, describe :

_____

11. Are you experiencing difficulty with appetite or changes in eating patterns? Yes ☐ No ☐
If yes, describe :

_____

12. Have you ever experienced domestic violence, abuse, or other violence in adulthood?
Yes ☐ No ☐ N/A ☐
If yes, please explain:

_____

13. Have you experienced abuse in childhood? PLEASE CIRCLE ALL THAT APPLY.
physical emotional verbal sexual mental neglect abandonment bullied
other (explain below)

_____
_____
_____
_____

14. Are you currently, or have you ever physically harmed another person? Yes ☐ No ☐
If yes, explain:

_____

15. Are you currently involved in legal proceedings? Yes ☐ No ☐
If yes, explain:

_____

16. Do you ever see or hear things other people say they can't see or hear?
If yes, please explain:

_____

17. Have you experienced significant life changes or stressful events recently?
If yes, please explain:

_____

18. Who is currently monitoring your medication (if any) for psychological problems?
_____ Phone:_____
May I contact this physician? Yes ☐ No ☐ (If 'Yes' please sign consent)

19. If there are any other medical or physical problems, which you feel might be important to my ability to be of help to you, please explain here:
_____

20. Who is your current physician? _____ Phone:_____
May I contact this physician? Yes ☐ No ☐ (If 'Yes' please sign consent)