PATIENT INTAKE PART A

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Please fill this form and bring to our first scheduled appointment.

FILL AS BEST AS POSSIBLE AND PLEASE PRINT CLEARLY. WRITE N/A WHERE IT DOES NOT APPLY. IF YOU HAVE QUESTIONS. PLACE A NOTE IN THE MARGIN SINCE WE WILL BE REVIEWING THE FORM TOGETHER.

NAME: ______________________________ **TODAY'S DATE:** __________

Name of parent/guardian (if patient is a minor) & RELATIONSHIP:

ADDRESS:

______________________________ **CITY**__________ **STATE**_____ **ZIP CODE**________

Home Phone: ______________________ May we leave a message? □Yes □No

Cell/Other Phone: ______________________ May we leave a message? □Yes □No

E-mail: ______________________ @ ______________________

May we e-mail you? □Yes □No

*Please be aware that email sometimes might not be confidential.

SEX: □**MALE** □**FEMALE** **AGE:** ______ **D.O.B:** __________ **SS#**__________________

MONTH / DAY / YEAR

CLIENT STATUS: □ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

EMPLOYED: □**YES** □ **NO** **RETIRED:** □**YES** □ **NO** **STUDENT:** □**FULL-TIME** □ **PART-TIME**

EMPLOYER'S NAME/SCHOOL:

REFERRED BY:

Are you currently receiving psychiatric services, professional counseling, or psychotherapy? Elsewhere? □Yes □No

Have you had previous psychotherapy? □Yes □No

Therapist / Psychiatrist name and Phone ______________________________

Are you currently taking prescribed medication ?

□Yes □No If Yes, please list All: ______________________

____

____

If no, have you been previously prescribed psychiatric medication? □Yes □No

If Yes, please list: ____

Do you regularly use alcohol? □ No □ Yes In a typical month, how often do you have 4 or more drinks in a 24-hour period? ____

How often do you engage recreational drug use?	□ Daily □ Weekly □ Monthly □ Rarely □ Never

MAIN PRESENTING PROBLEM OR PRECIPITATING FACTOR IN YOUR OWN WORDS:

____

____

____

____

____

Have you ever experienced?

MARK WITH 'X' ALL THAT APPLY			
EXTREME DEPRESSED MOOD		AGITATED	
FATIGUE		FAST BREATHING	
SLEEPING TOO MUCH		WORRY	
SLOWED DOWN		ANGER	
LOSS OF INTEREST IN USUAL ACTIVITIES		SHORTNESS OF BREATH	
DIFFICULTY SLEEPING		HEARING VOICES	
POOR CONCENTRATION		SEEING SHADOWS	
WILD MOOD SWINGS		FEEL LIKE SOMEONE IS FOLLOWING	
INTERRUPTED SLEEP		IRRITABLE	
NIGHTMARES		REPETITIVE BEHAVIORS	
FEELING DISSATISFIED		REPETITIVE THOUGHTS	
FEELING ISOLATED		BODY IMAGE PROBLEMS	
FEELINGS OF WORTHLESSNESS		EATING DISORDER	
PHOBIAS		FREQUENT BODY ACHES	
UNEXPLAINED MEMORY LAPSES		FEEL LIKE HURTING YOURSELF?	
UNEXPLAINED LOSSES OF TIME		FEEL LIKE HURTING ANOTHER PERSON?	
FEAR		OTHER:	

OCCUPATIONAL / SCHOOL INFORMATION:	Please list all related work/retirement/school stressors:
What is your job position/	
Are you retired?	
How many years in job/retired? If in school circle one: Freshman Sophomore Junior Senior	
Are you happy with your current retirement /position/school?	

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? □ No □ Yes If yes, what is your faith?

If no, do you consider yourself to be spiritual? □ No □ Yes

FAMILY MENTAL HEALTH / MEDICAL / SOCIAL HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (check all that apply):

	YOUR SELF	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
MENTAL ILLNESS							
DEPRESSION							
ANXIETY DISORDERS							
SCHIZOPHRENIA							
ALCOHOL ABUSE							
ILLEGAL DRUG ABUSE							
EATING DISORDERS							
LEARNING DISABILITIES							
TRAUMA HISTORY							
SUICIDE ATTEMPTS							
MENOPAUSE							
EPILEPSY							
ALLERGY							
HEART DISEASE							
HYPERTENSION							
HIV / AIDS							
DIABETES							
CANCER							
OTHER TERMINAL ILLNESS							
JAIL SENTENCE							
DOMESTIC VIOLENCE							
RELOCATED FROM COUNTRY OF ORIGIN							
SEPARATION / DIVORCE							
DEATH OF A LOVED ONE							
BANCKRUPCY							
LOSS OF JOB							
OTHER:							

HEALTH AND SOCIAL INFORMATION

Although some information may seem repeated, please answer as best as possible. Thank you.

1. How is your physical health at present?

   □ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

____

____

3. Are you having any problems with your sleep habits? □ No □ Yes
   If yes, check where applicable:
   □ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams
   □ Explain ____

4. How many times per week do you exercise? ____ Approximately how long each time? ____

5. Are you having any difficulty with appetite or eating habits? □ No □ Yes
   If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting
   In the last 2 months: Have you experienced significant weight gain? □ No □ Yes How much?___
   Have you experienced significant weight loss? □ No □ Yes How much?___

6. Are you currently in a romantic relationship? □ No □ Yes
   Are you Married? □ No □ Yes
   If yes, how long have you been in this relationship? __________________
   How would you rate the quality of your current relationship?
   □ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

7. What is your ethnic background? Are you proud of your ethnic heritage. Is it very predominant within your family customs? Is there an ethnic clash between you and your significant other?

8. What do you consider to be your strengths?

9. What do you like most about yourself?

10. What are effective coping strategies that you've learned?

11. How do you cope with change?

12. What are your goals for therapy?

Mark and Comment on any significant life changes coming up or you've had In the last 2 years:

STRESSOR	X	Comment
Death of a Spouse		
Death of a child		
Death of a sibling		
Death of a Parent		
Death of close friend / Family Member		
Trouble with in-laws		
Retirement		
Son or daughter leaving home		
Son or daughter returning home		
Your or spouse's loss of job		
Business readjustment		
Trouble with boss/co-worker		
Change in work responsibilities / hours		
Bad health diagnosis- yourself		
Bad health diagnosis-loved one		
Marriage / Engagement		
Marital Reconciliation / Separation		
Divorce		
Pregnancy		
Change in number of family members		
"Visitors" staying at home		
Needing a vacation		
Just returned from a vacation		
Quitting bad habit i.e.: smoking		
Dieting		
Outstanding personal achievement		
Superior success of a significant other		
Promotion		
Financial instability		
Foreclosure / Bankruptcy		
Purchase of a home		
Selling your home		
Spouse loses job		
Spouse begins to work		
Jail term		
Legal case pending		
Minor violations of the law		
Vacations coming up		
Holidays coming up		
Anniversary coming up		
Birthday coming up		
Sex difficulties		
Argument with family/friend/neighbor		
Friendly Neighbors moving away		
Changes within the community		
Changes in other living conditions		

PLEASE BRING A COPIES OF YOUR INSURANCE CARDS ON YOUR FIRST VISIT

CLIENT'S PRIMARY INSURANCE : ______________________________ **CO-PAY: $**__________

ID NUMBER: ____________________**GROUP NUMBER:** ______________________

EFFECTIVE DATE: ______________ **PLAN CODES:** ______________**PLAN TYPE:** ______________

INSURANCE SERVICE PHONE: ____

CLAIMS ADDRESS: ____

MAJOR MEDICAL CO-INSURANCE: ____

MAJOR MEDICAL DEDUCTIBLE- SINGLE: $**______________ **FAMILY:$ ______________

INSURED'S NAME:______________________________ **INSURED'S DATE OF BIRTH**____________

MONTH / DAY / YEAR

CLIENT'S RELATIONSHIP TO INSURED: ___**SELF** ___**SPOUSE** ___**CHILD** ___**OTHER**

INSURED'S ID NUMBER: ____________________**GROUP NUMBER:** ____________________

INSURED'S ADDRESS IF DIFERENT FROM CLIENT:

____

INSURED'S TELEPHONE:

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