INTAKE FORM Today's Date _______________

Name ___________________________________ Gender ____________ Date of Birth ________

Street address: ____

City _______________________________ State ______________ZIP _____________________________

Home/evening phone: ______________________________ e-mail:________________

Calls or e-mail will be discreet, but please indicate any restrictions: _____________________________________

Referred by ____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No
How did this person explain how I might be of help to you? ____

Person to contact in an emergency _________________________ Phone (___)-_______________________

Address ____ Relationship to you ____________________

Persons with whom you live and their relationship to you:
____
____

Children: NO _____ YES____ (Please answer bellow)

Name ____________________ Age ___________
____________________ ___________
____________________ ___________

Your Occupation or work emphasis ______________________________________ Years of Education _______

Education major or training emphasis____

Employer____ Years worked there _____________

Marital status (i.e. single, married, separated, divorced, living with partner) _________

Spouse/partner name ___________________________ Spouse/partner occupation _________________

Religious and racial/ethnic identification
Current religious denomination/affiliation ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu

Other (specify): __________________________________

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? ____

Which (if any) church, synagogue, temple, or meeting are you involved with? ______________________________

Ethnicity/national origin: _____________________________ Race: ________________________ or other similar way

you identify yourself and consider important: ____

Outpatient Medical Record - Please check all those that have occurred at any time. Head injury___ Learning Problems ___ Alcoholism___ Substance Abuse___Hepatitis___ Chicken Pox___ Rheumatic Fever__Thyroid Problems__ Whooping Cough__ Hernia___Cancer/Tumor___ Poliomyelitis___ Sinus Problems____ Food Intolerance___Speech Problems__ Epilepsy___ Bronchitis___ Measles___ Scarlet Fever___Typhoid Fever___ Hearing Problems___ Asthma___Mumps___Bulimia/Anorexia___ Tuberculoses___ Special Diets___ STD___ Appendicitis___ Hypertension___ Stroke___ Anemia___ Kidney Disease___ Diabetes___ Smallpox___ Tonsillitis___ Pregnancies___Heart Palpitations___ Pneumonia___ Neurological disease________Other
____

Gastrointestinal problems: _________________________Significant weight loss/gain ___________________________
Allergies (food, drug, other: please list)________________________ HIV Positive? Yes ____ No ____ How Long? _________

Do you experience any of the following? Abdominal Pain_______ Changes in Appetite_______ Dizziness_______Bed Wetting_________ Headaches_____________ Fatigue_________Frequent Urination_____ Fainting Spells___________ Chest Pain______ BreathingProblems_______Nausea_________Colds_______________Nosebleeds____Constipation_____Sore throat___________ Coughs________________ Toothache_______ Menstrual Problems____ Diarrhea_____________ Vomiting_______________ Ear Infection_____ Eye Vision Problems___ Memory Problems ____

List any operations, Medical Procedures or Hospitalizations for medical, psychiatric/emotional, drug or alcohol problems. Please include Dates. ____
____

Prescription drugs taken currently or in the past 6 months:

Prescription drug name	Reason Prescribed	Frequency/dosage
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Note any of the side effects of adverse reactions to medications listed above:
____

Legal Status i.e. Are you currently involved with the criminal justice system?
____

Chemical use

1. How many cups of regular coffee do you drink each day? _____ How many cups of tea? ____. How many sodas with caffeine (Coke, Pepsi, Mountain Dew, Dr. Pepper, Orange Crush, etc.)? ____ How many “energy drinks”? ____ How often do you use No Doz or similar caffeine pills? _______ .
2. How much tobacco do you smoke or chew each week? ____
3. Have you ever felt the need to cut down on your drinking? ❑ No ❑ Yes
4. Have you ever felt annoyed by criticism of your drinking? ❑ No ❑ Yes
5. Have you ever felt guilty about your drinking? ❑ No ❑ Yes
6. Have you ever taken a morning “eye-opener”? ❑ No ❑ Yes
7. How much beer, wine ,or hard liquor do you consume each week, on the average?
____
8. Are there times when you drink to unconsciousness, or run out of money as a result of drinking? ❑ No ❑ Yes
9. Have you ever used inhalants (“huffing”), such as glue, gasoline, or paint thinner? ❑ No ❑ Yes If yes, which and when? ____

Which drugs (not medications prescribed for you) have you used in the last 10 years? __________________________
____
____

Please provide details about your use of these drugs or other chemicals,such as amounts,how often you used them, their effects,and so forth: ____

Please help me understand what problems brought you to this office.

Check all that apply: Marital___ Job___ Career_____ School___ Alcohol___ Substance Abuse___ Depression___ Moodiness__ Self Confidence___ illness___ Fatigue___ Psychological___ Children___ Family___ Sexual Problems___ Traumatic Experience___ Loneliness___

Other or elaborate on above ____

Are you currently having any suicidal ideation?____

Previous Counseling or Psychotherapy? (please designate when, where, with whom and whether it was as a child, adult, couple or court ordered)

____

Previous contact with psychiatrist for medication, or psychologist for psychological evaluation: YES ____ NO_____

____

Is there any other information you think we should know?

____

____

Patient's signature___________________________ Date ____/____/_______

Name (printed)_______________________________