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New Adult Patient Intake Form

Today's Date:_____ Referred by_____

General Information
Name _____ Date of Birth _____
Age _____ Gender _____
Street Address: _____
City, State, Zip: _____

May I send information/billing to this address? (circle) Yes No

Home Phone: _____ May I contact you at home?: Yes No
(Messages OK?) Yes No
Cell Phone: _____ May I contact your cell phone?: Yes No
(Messages OK?) Yes No

Email address: _____

My preferred method of communication and verification of appointments is:
cell phone home phone text message email

Employer: _____ Occupation: _____

Marital Status (circle one) Single
Cohabiting (# of years) _____
Married (#of years) _____
Divorced (#of years) _____
Widowed (#of years) _____

Spouse/partner's Info
Name of Spouse _____ Age _____ Birth date _____
Occupation _____ Years employed _____
Contact number _____

Name of Emergency Contact: _____ Relationship: _____
Emergency Contact's Phone #: _____

Marriage/Family Info
Date of Marriage _____ Length of Dating_____
Any previous marriage(s) (circle) Yes No If Yes, # _____
length of marriage(s) _____
How did previous marriage(s) end? _____

Children (circle) Yes No If yes, custody status: _____

Children or others living in the home:
Name _____ Age: _____relationship_____
Name _____ Age: _____relationship_____
Name _____ Age: _____relationship_____
Name _____ Age: _____relationship_____

Children not currently living with you:
Name _____ Age_____
Name _____ Age_____
Name _____ Age_____

Purpose for Visit
Reasons for attending therapy (sources of stress that brought you to therapy)?
1._____
2. _____

When did the(se) issue(s) arise? _____

Goals for therapy:
1._____
2._____

Problem Checklist (circle all that apply)

depressed mood	hyperactivity	marital conflict	post-abortion trauma
appetite disturbance	change of life stress	LGBT issues	chronic pain
sleep Disturbance	hallucinations	sexual abuse	suicidal thoughts
fatigue/low energy	aggressive behaviors	physical abuse	violence in the home
poor Concentration	bingeing/purging	emotional abuse	low self esteem
mood Swings	Anorexia	anger	divorce issues
agitation	family conflict	blended family	body image
elevated Mood	weight loss/gain	communication	infidelity
hopelessness	ADHD	employment issues	pornography
irritability	grief	spiritual issues	sex addiction
social Isolation	sexual Problems	gambling	sex offense history
worthlessness	phobias	Alcoholism	trauma
panic attacks	obsessions/compulsions	drug use	
self-harm/cutting	difficulty making friends	infertility	
financial problems	difficulty Keeping Friends	parent-child conflict	

How do these problems affect your daily functioning (ability to work, care for self and others, relationships, physical health, etc)?

_____

Psychiatric History
Are you currently receiving psychiatric services or psychotherapy elsewhere? Yes No
Prior outpatient therapy? Yes No
If yes, when and for how long? _____
Psychiatric and medical diagnoses _____
What was the focus of previous treatment? _____

Prior suicide attempts? Yes No
If yes, when? _____
Circumstances that led to the attempt: _____
Current suicidal thoughts Yes No
If yes, please describe: _____
_____

Prior hospitalization for mental/emotional problems? (circle) Yes No
If yes, please describe (year/duration/reason for hospitalization): _____
_____

Do you currently consume alcohol? Yes No

Date of last use _____ Amount _____ # of years used _____
Frequency (circle): daily 2-3x/week weekly monthly less than once a month

Do you currently use any substances/drugs? Yes No
Drug of choice _____
Date of last use _____ Amount _____ # of years used _____
Frequency (circle): daily 2-3x/week weekly monthly less than once a month

Medical History
Please provide name of any medication(s), dose, reason for taking, and prescribing Physician:
_____
_____

Do you have a Primary Care Physician (PCP)? Yes No
If yes, PCP Name:_____ Phone number: _____
Date of last visit to Physician: _____

Family Mental Health History:
Has anyone in your family (either immediate or extended family members) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty	Family Member
Depression	
Bipolar Disorder	
Anxiety Disorders	
Panic Attacks	
Schizophrenia	
Alcohol/Substance Abuse	
Eating Disorders	
Learning Disabilities	
Trauma History	
Suicide Attempts	

List any major non-psychiatric family health problems: _____
_____

Social Functioning
Religious affiliation: _____ Church affiliation: _____
Do you currently attend services? Yes No How often: _____

Circle which best describes the current relationships you have with friends:
I have several strong friendships
I have a few close friends
I have no friendships

Circle which best describes your current relationships with family:
I am close and feel support from my family
I am close to some family but others are a great source of stress and/or frustration
I have no close family.
My family is a source of great tension and anger.

What do you consider to be your strengths?: _____
_____

What do you like most about yourself? _____
_____

How many sessions do you think you'll need to get back on track:
I don't know 1-3 4-6 7-9 10-12 Other

Would you like to be added to my email list to receive information about upcoming therapeutic opportunities and issues including groups and classes? Yes No

Additional Information that will be helpful for me to know:

*Please note that if you would like to seek reimbursement from your insurance company, I will give you a form to send to your insurance company and require the following information to complete the form. This form is not a guarantee for reimbursement. Contact your insurance for additional information regarding out of network benefits.

Insurance Company_____ Phone#_____

Ins.Co.Address_____

City_____ State_____ Zip_____

ID#_____ SS#_____ Group#_____

Do you have additional insurance (yes/no)? _____