Intake Information

Date Completed (Mo/Day/Yr) _____ Date of Intake _____

(Miss Ms Mrs Mr Dr)

First Name _____ Middle _____ Last_____

Prefer to be called _____ Gender _____

Birth Date (Mo/Day/Yr) _____ Age _____

Marital Status: Single Married Partnered (significant long-term relationship)

Divorced Separated Widowed

Please include at least one phone number. Email is optional ** If you choose email as preferred contact, you agree to email limitations in consent form**

Address _____

_____

Home Phone _____ Cell _____ Work _____

Email Address _____

Preferred contact info: home/cell/work/email May a message be left on phone? Y/N

Do you want to use Insurance for this and/or future visits Y/N

Spouse/Partner's Name _____ BirthDate (Mo/Day/Yr) _____

Spouse/Partner's Address (if different from above) _____

_____

Spouse/Partner's Phone/Contact Info

Home Phone _____ Cell _____ Work _____

Email Address _____

Is Spouse/Partner your First emergency Contact? Y/N

 Diagnosis_____

Other Emergency contact Name _____

Emergency contact phone number (s) _____

Relationship to client _____

Any Relevant Treating Physician names (e.g. primary care MD, psychiatrist, specialist for medical condition which affects presenting problem) and contact information

_____

_____

Occupation _____ Employer/School _____

Employer's Address (if using insurance) _____

Employer's Phone _____

Please let me know who referred you: _____

The following questions are to help me understand you as a person better, and to be more efficient during our initial appointment(s).

What is your primary reason for seeking help at this time:

Diagnosis_____

Please circle if any of the below listed issues have been a problem for you now or in the past.

Issue	Current/ Past	How severe is/was this for you? L = low M = Medium H = High
Abuse (Emotional/ Physical/ Sexual)	C P	L M H
Academic Problems	C P	L M H
Addictive/Compulsive Behaviors (internet use, gaming, gambling, spending $$, etc.)	C P	L M H
Alcohol Use	C P	L M H
Anger	C P	L M H
Anxiety	C P	L M H
Assault (Physical/Sexual)	C P	L M H
Attention Problems	C P	L M H
Body Image	C P	L M H
Death of Close Friend/Colleague	C P	L M H
Death of Family member	C P	L M H
Depression	C P	L M H
Domestic Violence	C P	L M H
Drug Use (unprescribed misuse of drugs or medications)	C P	L M H
Eating Problem	C P	L M H
Family Conflict	C P	L M H
Impulsivity	C P	L M H

Diagnosis_____

Legal Action or School/Work Discipline	C P	L M H
Issue	Current/ Past	How severe is/was this for you? L = low M = Medium H = High
Mania/Hypomania	C P	L M H
Medical Illness/Injury	C P	L M H
Relationship Problems (family, romantic, friendships, peer relationships, etc)	C P	L M H
Self-Injury	C P	L M H
Sexual Identity Concerns	C P	L M H
Sleep Difficulty	C P	L M H
Suicide Attempt	C P	L M H
Suicidal Ideation	C P	L M H
Trauma (major accident, natural disaster, combat, victim/witness to crime)	C P	L M H
Unusual Thoughts or Perceptual Experiences	C P	L M H
Workplace Stress	C P	L M H
Violent Behavior/Thoughts	C P	L M H
Other:	C P	L M H

Have you ever been given a mental health diagnosis? If so, what was it?

If you are taking any medications (prescription or over-the-counter) or herbal preparations, please list them below. Please provide dose, frequency, and purpose if you know them.

Diagnosis_____

Have you ever received mental health/behavioral health services previously? Y/N

Name of Provider/Facility	Approximate Dates of services	Contact information (if available

Please list those you consider to be in your current family:

Name	Age (d = deceased)	Relationship to you (Spouse/partner/child/stepchild/parent/in-law/etc)	Living with you? (Y/N)

Please list those from your family while growing up:

Name	Age (d = deceased)	Relationship to you (Parent/brother/sister/stepparent/ stepsibling/grandparent/etc)	Lived with you? (Y/N)

Has anyone in your family ever had a mental health issue or diagnosis? If so, please list family member and problem/diagnosis (if known).

Diagnosis_____