

Confidential Patient Intake Form

Name

.....

Address

.....

Phone

.....

May I leave a message for you at this number?

.....

Cell Phone

.....

Local Emergency Contact, Name and Phone Number:

.....

.....

Email

.....

I would like to receive monthly email newsletters with wellness tips and special offers.

Please circle: YES or NO

Parent or Guardian if you are under 18

.....

Please circle:

Married Never Married Domestic Partnership Separated Divorced Widowed

Currently in a romantic relationship Length of time on any of the above

.....

Please list preferred form of communication

.....

Employer

.....

Date of Birth (month, day and year)

.....

Gender

.....

Children, please list with age

.....

.....

Who were you referred by

.....

Have you been in therapy before

.....

Please list the last mental health professional you saw

.....

Please list any medications you are currently taking

.....

Please list any health problems you currently have

.....

Do you smoke

.....

Do you drink alcohol

.....

Do you engage in recreational drug use (how often)

.....

.....

Have you ever taken psychiatric medication?

.....

Please list the psychiatric medication with dates

.....

.....

.....

Are you religious or spiritual (please state faith or belief)

.....

Current state of physical health

.....

Do you have any current health issues

.....

.....

.....

Do you have sleep problems

.....

.....

How often do you exercise

.....

What type of exercise

.....

Are you experiencing problems with eating or loss /gain in appetite

.....



Are you currently depressed

.....

Have you recently experienced a death of a loved one (how long ago)

.....

.....

Do you have panic attacks

.....

Do you have any phobias

.....

Do you have chronic pain

.....

Date pain started and how often

.....

Have you recently experienced a stressful life event

.....

.....

Please list a family member for the any of the following:

Alcohol and or substance abuse

.....

Anxiety

.....

Depression

.....

Domestic violence

.....

Eating disorders

.....

Obesity

.....

Obsessive compulsive behavior

.....

Schizophrenia

.....

Suicide or attempts

.....

What would you like to get out of therapy or your reason for seeking therapy

.....

.....

Are you currently experiencing thoughts of harming yourself or someone else. If yes, please explain.

.....

.....



Cancellation Policy

We must be notified 24 hours in advance of a cancellation. If you do not notify us within 24 hours of your scheduled appointment you will be billed for your appointment. Please note if you miss your appointment due to an emergency you will not be billed.

Signature

.....

Date

.....