Intake Form

PERSONAL DATA: Date of Intake: ______________________
Patients Name :_____________________________
Relationship status (circle): Married Partnered Single Divorced Separated Widowed
Occupation ____
Employer ____
Who referred you? ____________________

AREAS OF CONCERN: What are the concerns that motivate you to seek evaluation / therapy?
____
____
When did these problems begin?
____
____
Are they getting better, worse or remaining the same? ____

PERSONAL & FAMILY HISTORY: Where were you born and/or grew up?____________________________
Was your birth normal? Yes___ No___ I don't know___ Describe any problems with your birth: _________
____
Developmental problems (walking, talking, etc)? ____
Did your parents divorce? Yes___ No___ How old were you when they divorced?__________

Number of siblings: ___Biological brothers ___Biological sisters ___Step brothers ___Step sisters
Were you the oldest, youngest, middle, or only child in your family?_____________
When you were a child, did you ever suffer from physical, sexual, verbal or mental abuse? (If yes, please briefly explain—who, what kind, how old were you?) ____
____
Would you describe your childhood as (circle): good, bad, traumatic, happy, sad, lonely, scary. Please give examples: ____
____

Number of Marriages: ________ Reasons for divorce(s): ____
____
Number of children: _______ Names and Ages: ___________, _____________, _____________, _____________
Do any of your children live with you now? ____
Current spouse/partner: Name __________________ Age ___ Education (# yrs) __ Occupation: ___________
Living together? Y N Explain: _____________________

EDUCATION: Highest level of education and grade point average:____________________________________
If you did not finish high school or college, please briefly explain why: _________________________________
____
Were you ever in special education classes?______ Did you ever repeat a grade?_______
Were you diagnosed with a learning disability? Yes___ No___ If yes, what was the learning disability?________
______________________ If not diagnosed, have you ever thought you had a learning problem?______________
Have you ever been diagnosed with an attention deficit/hyperactivity disorder (ADD/ADHD)? Yes_____ No_____
If not diagnosed, have you ever thought you had an attention deficit problem?______________________________
____

WORK HISTORY: Are you currently working? Y___ N___ If no, what is the reason for not working? _________
____
If you are working, what is your current job?_______________________ How long have you had this job?________

Did you serve in the armed forces? Y__ N__ What branch?____________ Dates of service:________________
Any combat experience (Where, When)?________________________________ Highest rank:_________________
Type of discharge:___________ Do you have a disability that is "service connected"? (If yes, please describe):
____

ARREST & LEGAL HISTORY: Have you been arrested Y____ N _____ Explain:___________________________
____
Involved in a case/litigation? Y___ N___ Explain: ____

DRUG & ALCOHOL HISTORY: Do you have a history of abusing alcohol or drugs? Yes___ No___
Describe any Alcohol use: Drinking now? Yes___ No____ How much and how often?________________________
Any Treatments for alcohol or drugs? Yes___ No___
If yes, when & where? ____
Do you currently smoke cigarettes? Yes___ No___ How much in a day? ___________

MEDICAL & PSYCHOLOGICAL HISTORY:
Please list any chronic medical illnesses (asthma, high blood pressure, diabetes, seizures, etc.): ________________
____
Have you ever been knocked out, suffered a concussion, lost consciousness, or suffered a severe closed head injury? Yes___ No___ If yes, explain: ____
If you have had a closed head injury, does it cause you limitations? _____ If yes, please explain how: ___________
____
List all past surgeries: ____
____
Do you suffer from chronic physical pain?_____ If yes, where do you experience pain? ________________________
____

(Where 0 is no pain at all & 10 is the worst pain imaginable, such that you would be unconscious):
Circle the number that describes you pain level on MOST days: 0 1 2 3 4 5 6 7 8 9 10
Circle your pain level at right this very moment: 0 1 2 3 4 5 6 7 8 9 10
Does pain cause you limitations in any of the following? (Circle all that apply): Walking, Standing, Sitting, Bending, Lifting. How long can you: Walk_________ Stand__________ Sit___________

Psychiatric:
Have you ever been hospitalized in a psychiatric hospital? Yes___ No___ If yes, how many times? ___________
Where & When? ____
____
____
What were the reasons you were hospitalized? (Circle all that apply): Depression Suicidal Manic Anxiety Other

Name of current Psychiatrist (if you have one): ____
Have you been in counseling / therapy in the past?_____ If yes, when & for what?____________________________
Names of previous counselors / therapists: ____

Please list all current medications you are taking (give names & dosages):
Name: ______________________________ (____mg) Name: ________________________________ (___mg)
Name: ______________________________ (____mg) Name: ________________________________ (___mg)

Please describe any major health, medical or mental health problems among the following family members:
Father _______________________________________ Mother _______________________________________
Sisters _______________________________________ Brothers ______________________________________
Children ______________________________________ Grandparents ___________________________________
Is your mother alive? Yes___ No___ Is your father alive? Yes___ No___

ACCIDENT / INJURY: Date of any Accidents/Injuries: ___/___/___ Description: ____________________________
____
____
____
____

DRUG OR FOOD ALLERGIES?____

ACTIVITIES OF DAILY LIVING: Who do you live with?____

Please describe a typical day:

Morning:____ Do you eat Breakfast? Yes___ No___

____

Noon: ____ Lunch? Yes___ No___

____

Evening: ____ Dinner? Yes___ No___

____

Circle all that you can physically do:Household chores, Errands, Shopping, Cooking, Dress yourself, Bathe yourself

Please describe how your ability to do any of the above activities are limited—Be specific: ____________________

____

What do you do for fun? (Hobbies & interests): ____

If you cannot do these activities now, why not? ____

____

Are you less social than you used to be? Y__ N__ - If yes, why? ____

____

Do you currently drive?____________If you do not, why not? ____

SPIRITUAL / FAITH BACKGROUND:

How do you describe yourself? (circle): Spiritual Religious Uncertain Other____________________

Spiritual affiliation(s): Present_________________________

PLEASE LIST SOURCES OF SUPPORT & STRENGTH IN YOUR LIFE: ___________________________________

____

____

Additional relevant information not report above:

I authorize my therapist and The Center for Behavioral Health to contact the following physician or therapist for additional information:

Name: __________________________ Address: ____

Phone: ___________________________

In case of an emergency, I authorize The Center for Behavioral Health to contact the following person(s):

Name__________________________________ Relationship______________ Phone: (______)_____________

Name__________________________________ Relationship______________ Phone: (______)_____________

____ ____/____/_____

Patient Signature Date of Signature

Intake Interview

DSM IV Diagnosis:

Axis I: __________ Axis II: ___________ Axis III: ___________ Axis IV: __________ Axis V: _____________

Mental Status Exam: Affect _____________ Speech _______________ Mood ____________
Judgment ____________Thought content _____________ Insight ______________ Attention ____________
Memory ______________ Impulse Control ______________

Suicide Attempts? _________ Ideation: _________ Explain: ____
____

Treatment Goals and Time frame to achieve: ____
____
____
____

Community resources receiving?: (support groups, social services, school services)
____

Communicated with Primary Care Doctor or relevant physician or therapist? Y or N ______ Date: ___________

Comments: