Kate Hinkle, PsyD
312.544.9166
kate@drkatehinkle.com

New Patient Intake Form

What are your current concerns?

_____

_____

_____

What are your treatment goals?

_____

_____

_____

Current Symptoms Checklist:

___ Depressed mood
___Unable to enjoy activities
___Loss of interest
___Change in appetite
___Change in sleep
___Excessive Fatigue
___Changes in sexual desire/activity
___Suicidal thoughts
___Suicidal plan/intent
___Self harm thoughts/behaviors
___Anxious mood
___Excessive worry
___Racing thoughts
___Anxiety/panic attacks
___Difficulty concentrating/forgetfulness
___Increased impulsivity
___Increased irritability
___Traumatic event/experience(s)

List and current or previous mental health treatment and diagnoses:

_____

_____

_____

List all current medications and the name of the prescribing physician (prescribed, supplements, over the counter):

_____

_____

Current or chronic medical concerns:

_____

_____

Substance Use History:

Do you use alcohol? ___Yes ___No

How many days per week do you use alcohol? _____

What is the least number of drinks per day _____ and most number of drinks per day_____?

Are you concerned with your alcohol use? ___Yes ___No

Have you been concerned with your alcohol use in the past? ___Yes ___No

Have you received treatment for alcohol use? ___Yes ___No

Do you use marijuana? ___Yes ___No

How many days per week do you use marijuana? _____

What is the least amount of use per day _____ and most amount of use per day_____?

Are you concerned with your marijuana use? ___Yes ___No

Have you been concerned with your marijuana use in the past? ___Yes ___No

Have you received treatment for marijuana use? ___Yes ___No

Other substances that you currently use or have used in the past (if current, please indicate frequency and amount):

_____

_____

Is there anything else you would like me to know?

_____

_____

_____