Medical Centre

CBT Intake Form

Patient Information

Patient Name: ____ **Preferred Name:** ____________________
Last First

Date of Birth: ________/__________/__________ **Age:** ______________ **Gender:** ___________________
MM DD YYYY

Best contact phone number: ________________________ **Email address:** _______________________________

Address: ____

Primary Care Physician: __________________________ **Physician Phone Number:** _______________________

Current marital status:

- Single, never married
- Separated
- Cohabiting with partner
- Married, living together
- Divorced
- Other: _______________
- Married, not living together
- Widowed

On a scale from 1-10 how would you rate your current relationship? _______________

Highest Degree Obtained:

- High school graduate
- G.E.D
- Technical Diploma
- 4 year college degree
- M.B.A/ M.A. / M.S.
- Ph.D
- J.D. / LL.B.
- M.D.
- Other: __________________________________

What best describes your current employment status:

- Unemployed, looking for employment
- Unemployed, not looking for employment
- Full-time employed
- Part-time employed
- Self-employed
- Retired

What is your occupation? ____

Current Residence

- Own my house / condo
- Apartment / Condominuim
- Renting
- Student Housing
- Other: ____

Patient Name: ____________________________________

Psychiatric History

Briefly State the primary reason for your visit today:

- O Anxiety
- O Depression
- O Panic Attacks
- O OCD
- O Relationship Issues
- O Work Stress
- O Other: ____

Are you currently receiving mental health care? O Yes O No

(If yes) Name: ______________________________ Contact Number: ____________________________

Have you ever seen a psychiatrist / psychotherapist before? O Yes O No

(If yes) Name: ______________________________ Contact Number: ____________________________

Have you ever been treated for any of the following (check all that apply):

	Depression		ADHD		Alcohol Problems		Bipolar Disorder
	Anxiety		OCD		Substance Abuse		Personality Disorder
	Schizophrenia		PTSD		Anorexia / Bulimia		Suicidal / self-injuring behavior
	Panic Attacks		Phobias		Binge-eating		Problems coping with stress
Other:							

Have you ever been hospitalized for psychiatric reasons? O Yes O No

(If yes) Provide details: ____

____

Have you ever attempted to kill or harm yourself? O Yes O No

Please list all current medications below:

Name of medication Dosage
____
____
____
____

Have you been prescribed psychitric medication in the past O Yes O No

(If yes) Please list: ____

____

Patient Name: ______________________________________

Family History

Has anyone in your family ever been treated for any of the following?
If yes, please indicate on the line which family member and, if applicable, whether on mother's or father's side.

- ○ Depression ____
- ○ Anxiety ____
- ○ Panic Attack ____
- ○ PTSD ____
- ○ ADHD ____
- ○ Substance Use ____
- ○ Alcohol Problem ____
- ○ Personality Disorder ____
- ○ Bipolar / Manic Disorder ____
- ○ Suicide Attempts ____
- ○ Psychiatric Hospital stay ____

Medical History

Do you have any medical conditions that you are receiving treatment for? ○ Yes ○ No
If yes, please list:

____

____

ALLERGIES TO MEDICATION: ____

Do you drink alcohol? ○ Yes ○ No

If yes, how many drinks do you have on average each week? ______________________

Do you use tobacco? ○ Yes ○ No

Do you exercise? ○ Yes ○ No

If yes, how often per week? ____

Do you sleep well? ○ Yes ○ No

Do you have any concerns for any type substance abuse, including cutting down? ○ Yes ○ No

Do you have a history of substance abuse? ○ Yes ○ No

Patient Name: ______________________________________

History

Do any of the following apply to you?

- ○ Problems with family or friends . *Specify* ______________________________
- ○ Problems with your current partner. *Specify* ______________________________
- ○ Emotional problems. *Specify* ______________________________
- ○ Occupational problems. *Specify* ______________________________
- ○ Housing problems. *Specify* ______________________________
- ○ Economic problems. *Specify* ______________________________
- ○ Problems with sleep. *Specify* ______________________________
- ○ Problems related to interaction with the legal system / crime. *Specify* ______________________________
- ○ Problems with time management and organization. *Specify* ______________________________
- ○ Other psychosocial and environmental problems. *Specify* ______________________________

Goals

What outcomes are you seeking by attending therapy at this time?

Is there anything else you would like your Doctor to know about you or your reason for seeking treatment regarding you mental health?

The following are a list of questionnaires used to evaluate different symptoms related to **Anxiety, Depression, and Social Phobia**. Please fill out ONLY what is relevant to your symptoms. Kindly return unused questionnaires to the reception.

Patient Signature:______________________________ **Date:** ______________________________

Patient Name: ____________________________________

Beck Anxiety Inventory

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not At All	Mildly but it didn't bother me much.	Moderately - it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding/racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot/cold sweats	0	1	2	3
Column Sum				

Scoring - Sum each column. Then sum the column totals to achieve a grand score. Write that score here ____________ .

Patient Name: ___________________________________

PHQ-9 depression questionnaire

Over the LAST TWO WEEKS, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Total ___ =	**___**	**+ ___**	**+ ___**	**+ ___**
PHQ-9 score ≥10: Likely major depression				
Depression score ranges:				
5 to 9: mild				
10 to 14: moderate				
15 to 19: moderately severe				
≥20: severe				
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ___	Somewhat difficult ___	Very difficult ___	Extremely difficult ___

Patient Name: ______________________________________

Social Phobia Inventory

Please read each statement and click in the column that indicates how much the statement applied to you over the past week.

	Not at all	A little Bit	Somewhat	Very much	Extremely
1. I am afraid of people in authority.					
2. I am bothered by blushing in front of people.					
3. Parties and social events scare me.					
4. I avoid talking to people I don't know.					
5. Being criticized scares me a lot.					
6. I avoid doing things or speaking to people for fear of embarrassment.					
7. Sweating in front of people causes me distress.					
8. I avoid going to parties.					
9. I avoid activities in which I am the center of attention.					
10. Talking to strangers scares me.					
11. I avoid having to give speeches.					
12. I would do anything to avoid being criticized.					
13. Heart palpitations bother me when I am around people.					
14. I am afraid of doing things when people might be watching.					
15. Being embarrassed or looking stupid are among my worst fears.					
16. I avoid speaking to anyone in authority.					
17. Trembling or shaking in front of others is distressing to me.					