New Patient Intake

If you are uncertain what kind of information to provide, please kindly let me know and we can discuss it together.

A. Identification.

Your name:_____ Date of birth:_____ Age:_____

Nicknames or aliases:_____ Social Security Number: _____

Home street address:_____ Apt:_____

City:_____ State:_____ Zip:_____

Home/evening phone:_____ E-mail:_____

Calls or e-mail will be discreet, but please indicate anyrestrictions: _____

B. Religious and racial/ethnic identification.

Current religious denomination/affiliation ❑ Protestant ❑ Catholic ❑Jewish ❑Islamic ❑Buddhist ❑Hindu

Other (specify): _____

Involvement: ❑None ❑Some/irregular ❑Active

How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, or meeting do you attend? _____

Ethnicity/national origin:_____ Race(s):_____

Other ways you identify yourself and consider important: _____

C. Your medical care.

From whom or where do you receive your medical care? _____

Phone:_____ Address:_____

Any chronic pain or serious health concerns? _____

List current and previous medical problems you have had:

Dates of illness	Type of Treatment Received	Outcome of Treatment?

If you enter treatment with me for Mental health concerns, may I tell your medical doctor so that she or he can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

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D. Chief concern.

Please describe the main difficulty that has brought you to see me: _____

_____

_____

_____

What kind of stressors are you experiencing right now? _____

_____

_____

_____

What important things about you, your relationships or family would it be helpful for your therapist to know? (i.e., handicaps, deaths, divorces, school/job changes, suicide) _____

_____

_____

_____

Please check any of the following that applies:

❑ Plans to harm self

Explain: _____

❑ Intentions to harm self

Explain: _____

❑ Attempts to harm self

Explain: _____

❑ Psychiatric Hospitalizations

Explain: _____

❑ attempted suicide

Explain: _____

❑ Suicidal now

Explain: _____

E. Treatment.

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

❑ No ❑ Yes If yes, please indicate:

When? From whom? For what? With what results?

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2. Have you ever been hospitalized for mental or nervous problems?

❑ No ❑ Yes If yes, please indicate:

When? From whom? For what? With what results?

3. Have you ever taken medications for psychiatric or emotional symptoms? ❑ No ❑ Yes If yes, please indicate: When?

From whom? Which medications? For what? With what results?

I. Relationships in your family of origin.

Please describe the following:

1. Your parents' relationship with each other:

2. Your relationship with each parent and with any other adults present:

3. Your parents' medical problems, drug or alcohol use, and mental or emotionaldifficulties:

4. Your relationship with your sibling(s), in the past and present:

J. Abuse history.

❑ I was not abused in any way. ❑ I was abused.

If you were abused, please indicate the following. For kind of abuse, use these letters: P = Physical, such as beatings.

S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or

PROTECT. E = EMOTIONAL, SUCH AS HUMILIATION, ETC.

AGE?	KIND OF ABUSE?	BY WHOM?	EFFECTS ON YOU?	WHOM DID YOU TELL?	CONSEQUENCES OF TELLING?

K. PRESENT RELATIONSHIPS (IF APPLICABLE).

1. ARE YOU SINGLE, MARRIED, DIVORCED, OR SEPARATED? _____
2. IF MARRIED, DATE OF CURRENT MARRIAGE: _____
3. SPOUSE'S NAME: _____ DATE OF BIRTH: _____
4. PLEASE LIST ADDITIONAL FAMILY MEMBERS LIVING WITH YOU:

NAME	RELATIONSHIP	DATE OF BIRTH	EMPLOYER/SCHOOL

5. HOW DO YOU GET ALONG WITH YOUR PRESENT SPOUSE/PARTNER AND/OR CHILDREN? _____

L. EMERGENCY INFORMATION.

IF SOME KIND OF EMERGENCY ARISES AND WE CANNOT REACH YOU, OR WE NEED TO REACH SOMEONE CLOSE TO YOU, WHOM SHOULD WE CALL?

NAME: _____ PHONE _____ RELATIONSHIP: _____

M. INSURANCE INFORMATION.

PRIMARY INSURANCE COMPANY: _____ PHONE NUMBER: _____

CLAIMS ADDRESS: _____

POLICY HOLDER NAME AS IT APPEARS ON THE CARD: _____

POLICY HOLDER DATE OF BIRTH: _____ POLICY HOLDER SOCIAL SECURITY NUMBER: _____

POLICY HOLDER RELATIONSHIP TO PATIENT: _____

IF YOU ARE NOT SUBMITTING CLAIMS TO YOUR INSURANCE COMPANY, THEN TO WHOM SHOULD YOUR BILLS BE DIRECTED:

❑ SELF

❑ OTHER: _____

(NAME) (ADDRESS) (PHONE

Please mark all the items below that apply, and feel free to add any others at the bottom under "Other concerns or issues" option. You may add a note or details in the space next to the concerns checked.

- ❑ I have no problem or concern bringing me here
- ❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Aggression, violence
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your childhood)
- ❑ Codependence
- ❑ Compulsions
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Housework/chores—quality, schedules, sharing duties
- ❑ Inferiority feelings
- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Judgment problems, risk-taking
- ❑ Legal matters, charges, suits
- ❑ Loneliness
- ❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ❑ Memory problems
- ❑ Menstrual problems, PMS, menopause
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Nervousness, tension
- ❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ❑ Oversensitivity to rejection
- ❑ Pain, chronic
- ❑ Panic or anxiety attacks
- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination, work inhibitions, laziness

- ❑ Relationship problems (with friends, with relatives, or at work)
- ❑ School problems (see also “Career concerns ...”)
- ❑ Self-centeredness
- ❑ Self-esteem
- ❑ Self-neglect, poor self-care
- ❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also “Abuse”)
- ❑ Shyness, oversensitivity to criticism
- ❑ Sleep problems—too much, too little, insomnia, nightmares
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stress, relaxation, stress management, stress disorders, tension
- ❑ Suspiciousness, distrust
- ❑ Suicidal thoughts
- ❑ Temper problems, self-control, low frustration tolerance
- ❑ Thought disorganization and confusion
- ❑ Threats, violence
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems, employment, workaholism/overworking, can’t keep a job, dissatisfaction, ambition
- ❑ Other concerns or issues:_____

_____

_____

SIGNATURE:_____ DATE:_____

PRINTED NAME:_____

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