INTAKE FORM WITH CONSENT FORMS ATTACHED

1. Please enter your information.

First Name: | Middle Initials: | Last Name: | Date of Birth:

Gender:
○ Female ○ Male ○ Other

Gender Identity and Preferred Pronouns

Street Address: | Apt./Unit #: | City: | State: | Zip Code:

Mobile Phone: | Home Phone: | Work Phone:

Email:

Preferred contact method:
○ Mobile Phone ○ Home Phone
○ Work Phone ○ Email

May we leave a message or text?
○ Yes ○ No

Preferred Language:
○ English ○ Spanish ○ Other:

If other, please specify:

Race (Please check all that apply):
☐ Prefer not to say ☐ White ☐ Black ☐ Asian
☐ American Indian/Native Alaskan
☐ Native Hawaiian/Pacific Islander ☐ Other:

If other, please specify:

Ethnicity:
☐ Prefer not to say
☐ Hispanic/Latino(a)

Employer:

How did you learn about this office?

Who referred you?

2. Please upload a copy of an Identification Card (with picture)

3. Emergency Contact Information.

Emergency Contact Name: | Relationship:

Address: | Apt/Unit #:

Phone Number: | Alt Phone Number:

4. Family Doctor: | Telephone #:

5. Do you have Medical Insurance?

○ Yes ○ No

6. Primary Insurance

Primary Insurance Company | Member ID / Policy # | Group Number

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name | Insured Phone # | Insured Date of Birth | Insured Sex ○ Female ○ Male

Insured Street Address | Insured City | Insured State | Zip Code

Do you have Secondary Insurance?
○ Yes ○ No

7. Secondary Insurance

Secondary Insurance Company | Member ID / Policy # | Group Number

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name | Insured Phone # | Insured Date of Birth | Insured Gender ○ Female ○ Male

Insured Street Address | Insured City | Insured State | Zip Code

8. Please upload a copy of your insurance card (front and back)

I authorize the release of any medical information necessary to process my claim and payment of benefits.

Signature | Date

9. What concern brings you in today?

10. How long have you had this problem?

Have you tried anything to manage this problem?

How severe is this problem?

Is this problem affecting your family life, work or sleep?

○ Yes ○ No

If yes, please explain:

11. Have you had any recent stressful events or significant life changes? (i.e. recent death, divorce, job loss)

12. What goal(s) do you have for this session?

13. What are your biggest strengths?

14. **Desire for Treatment - On a scale of 1 - 10 where: 1 - Someone forced me into seeking counseling. I am doubtful that counseling can help or I don't think I need any help. 10 - I want to be here and I am actively doing things to make changes in my life. I have been in counseling before and I want to continue or I am looking for additional support.**

- ○ 1 - Someone forced me into seeking counseling. I am doubtful that counseling can help or I don't think I need any help.
- ○ 2
- ○ 3 - I am reluctant to undergo counseling. I am unsure if there is anything I can change in my life, however I am willing to talk with someone.
- ○ 4
- ○ 5 - I am not sure, but I am here
- ○ 6
- ○ 7
- ○ 8 - I am prepared to undergo counseling. I still have some doubts, but there are things that I would like to change in my life.
- ○ 9
- ○ 10 - I want to be here and I am actively doing things to make changes in my life. I have been in counseling before and I want to continue or I am looking for additional support.

Why did you answer the number you did?

_____

MEDICAL AND HEALTH HISTORY

15. How would you rate your physical health?

○ Excellent ○ Good ○ Fair ○ Poor

16. **Do you have any of the following: (Check all that apply)**

- ☐ Diabetes
- ☐ Cancer
- ☐ Headache/Migraines
- ☐ Heart Disease/Stroke
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Thyroid Disease
- ☐ Substance Abuse

17. **Any other major medical conditions?**

○ Yes ○ No

18. **If yes, please list:**

_____

_____

_____

_____

19. **Do you have chronic pain?**

○ Yes ○ No

20. If yes, please explain:

21. List all medications you are taking, including any over-the-counter medications, herbs or vitamins:

	Medication	Dosage	Reason for Taking?
1			
2			
3			

22. Do you have any known allergies?

○ Yes ○ No

23. If yes, please list any allergies:

	Allergic to?	Reaction
1		
2		
3		

24. Do you smoke/vape nicotine?

○ Yes ○ No

25. If you smoke:

Packs/Day: Years:

26. Do you drink alcohol?

○ Yes ○ No

27. If you drink alcohol:

Drinks/Day: Years:

Have you ever felt a need to cut down on your drinking?

○ Yes ○ No

28. Do you drink caffeine?

○ Yes ○ No

If yes, Cups/day:

_____

29. Do you use pain medication daily?

○ Yes ○ No

30. If yes, please list:

_____

31. Do you use recreational drugs?

○ Yes ○ No

32. If yes, please list and describe frequency:

_____

33. Have you been arrested?

○ Yes ○ No

34. If yes, explain:

_____

_____

_____

_____

35. Do you have any concerns about sleep?

○ Yes ○ No

36. Have you been diagnosed with a psychiatric condition?

○ Yes ○ No

37. If yes, what:

_____

_____

_____

_____

38. Have you received mental health service(s) in the past?

○ Yes ○ No

39. If yes, please list reason for treatment and dates:

_____

_____

_____

_____

40. Do you have (or have you had) any of these concerns:

	Answer	Notes/Comments
Difficulty falling or staying asleep		No
Sleeping too little or too much		No
Daily feeling of sadness that doesn't go away		No
Panic/Anxiety attacks		No
Problems concentrating		No
Mood fluctuates up and down		No
Remembering upsetting things constantly		No
Upsetting thoughts I can't get out of my head		No
Repetitive behaviors I can't stop		No
Constant worrying		
Disordered eating/purging		
Sexual Abuse		
Physical/Verbal Abuse		
Feeling tired almost every day		
Questions about sexual identity		
Feelings of low self-worth		

Risky behaviors		
Difficulty controlling my temper		
Difficulty maintaining a job		
Difficulty paying for basic expenses		
Thoughts of killing or harming myself		
Attempts to kill or harm myself		
Hear or see things that other people do not		

SOCIAL HISTORY

41. Are you:

○ Married ○ Single ○ Domestic Partnership
○ Divorced ○ Widowed

Name of spouse/significant other:

_____

Do you have children?

○ Yes ○ No

Are you satisfied with your family life?

○ Yes ○ No

How would you rate your marital/significant other relationship?

_____

How would you rate your family relationships?

_____

What is the highest level of education you completed?

_____

Are you employed?

○ Yes ○ No

Occupation:

_____

How would you rate your work satisfaction?

_____

42. Do you see/talk to someone you feel close to more than once a week?

○ Yes ○ No

How would you rate your general sense of well-being?

_____

43. Do you consider yourself spiritual?

○ Yes ○ No

44. If yes, describe faith/spiritual practice:

_____

_____

_____

_____

FAMILY PSYCHIATRIC HISTORY

45. Do you have a family (parent, sibling or child) history of:

	Answer	If yes, who?
Alcohol/Substance Abuse		
Anxiety		
Depression		
Eating Disorder		
Obsessive Compulsive Disorder		
Schizophrenia		
Suicide		
Other:		

If other, please specify:

_____