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Intake Form

Please fill out this biographical background form as completely as possible. Please print or write clearly and bring it with you to the first session. Feel free to write on an additional sheet if you need more space.

Full Name:	**DOB:**	**Gender:** **Marital Status:**
Patient Address:		
Phone #:	Cell Phone #:	
Permission to leave message: ❑ Yes ❑ No	Permission to text: ❑ Yes ❑ No Permission for video visits: ❑ Yes ❑ No	

Referred by:	Permission to contact: ❑ Yes ❑ No
Phone:	Email:

Emergency Contact(s):	Permission to contact: ❑ Yes ❑ No
Name:	Phone #:
Name:	Phone #:

Payor/Guarantor:	Permission to contact: ❑ Yes ❑ No
Name:	Phone #:

PRESENTING PROBLEM(S)/ REASON FOR SEEKING TREATMENT:

(*USE OTHER SIDE OF PAGE TO ADD MORE INFORMATION if needed)*

Describe the problem that brought you here today:

_____

_____

_____

_____

Please check all of the behavior or symptoms that you consider problematic, CIRCLE any that are severe:

Mood: ☐Sadness/depression ☐Loss of pleasure/interest ☐Low self-worth ☐Loneliness ☐Lack of motivation ☐Fatigue ☐Thoughts of death ☐Hopelessness ☐Crying spells ☐Change in appetite ☐Sleep problems ☐Self-harm behaviors ☐Irritability/anger ☐Seasonal mood changes ☐Impulsivity ☐Withdrawal from people ☐Excessive Guilt or Shame ☐Excessive energy ☐ Times needing very little sleep ☐Racing thoughts ☐Wide mood swings ☐Excessive spending ☐Suspicion/paranoia ☐Hearing voices ☐Visual hallucinations ☐Feeling that world or self not real

Anxiety: ☐Anxiety/worry ☐Panic attacks ☐Ruminating thoughts ☐Social discomfort ☐Physical numbness/shakes/sweating

OCD: ☐Obsessive thoughts ☐Compulsive /Repetitive behaviors ☐Preoccupation with numbers or germs or order

Trauma ☐Flashbacks ☐Avoiding people/places ☐Disturbing memories ☐Nightmares ☐Emotional/Physical/Sexual Abuse

ADD: ☐ Poor Concentration ☐Hyperactivity ☐Memory problems/confusion ☐Disorganization

Addiction: ☐Alcohol/drug use ☐Gambling ☐Problems with pornography ☐Computer/Cell phone addiction

OTHER: ☐Aggression/fights ☐Homicidal thoughts ☐Blackouts ☐Eating problems ☐Dissociation ☐Binging/Purging

Are your problems affecting any of the following: ☐Handling Everyday Tasks ☐Relationships

☐Legal Problems ☐Recreational activity ☐Frequent arguments ☐Housing/Financial

☐Sexual Activity ☐Heatlh/ Hygiene ☐Parenting ☐Work/School

Have you had thoughts, made statements, or attempted to <u>hurt yourself or attempt suicide?</u> If yes, describe:

_____

_____

_____

Have you had thoughts, made statements, or attempted to <u>hurt someone else</u>? If yes, please describe:

_____

Have you recently been physically hurt or threatened by someone else? If yes, please describe:

_____

<u>ALL CURRENT MEDICATIONS including OVER THE COUNTER/HERBAL/SUPPLEMENTS</u> you are taking now:

(*USE OTHER SIDE OF PAGE TO ADD MORE INFORMATION ABOUT MEDICATIONS if needed)*

Medication	Reason for use	Dose per day	Duration (weeks)	Date of last use

EMPLOYMENT STATUS: ___ Part-time ___Full-time ___ Unemployed ____ Full-time Student ____Disabled
Place of Work:_____Position:_____
Work problems/Stressors:_____
Other Jobs Held: _____

EDUCATION LEVEL: Attending school: __Yes. ___No. High School Graduate? __Yes. ___No. GED__ Year___
College:___ Where attended_____. Date of degree conferral_____
Advanced Degrees or Certificates:_____

MILITARY SERVICE: Prior or current service in the military? If yes, describe:
_____

LEGAL: Describe any current or pending civil or criminal litigation/s, lawsuit/s or divorce or custody dispute:
_____
_____
Have you ever been convicted of a misdemeanor or felony? If yes, describe:
_____

RELATIONSHIP HISTORY:

Relationships	Quality of Relationship	Status:	History of Conflicts	Ongoing/Recent Contact:
Mother		**Divorced:** **Remarried:**		
Father		**Divorced:** **Remarried:**		
Siblings		**Number:** **Ages.**		
Spouse(s)/Partner(s)		**Years married:** **Living in household:**		
Children		**Number:** **Ages.**		
Other				

SOCIAL SUPPORT AND CURRENT STRENGTHS:
Please describe your social support network:
_____
_____
_____
Spiritual or religious orientation: Not at all Little Regular Very much
Describe your strengths and talents and any special areas of interest/hobbies/pursuits?
_____
_____
_____
_____

PSYCHIATRIC HISTORY:

Yes	No	Treatment	When? How long?	Provider/Program	Reason for Treatment
		Outpatient Counseling/Psychotherapy			
		Prior Psychiatric Medications			
		Psychiatric Hospitalizations			
		Intensive Outpatient			
		Self-help/Support Groups			
		Other			

Additional Information:

_____

_____

Family Mental Health Problems	**Who in your family?**
Anxiety	
Depression	
Bipolar Disorder	
Attention problems	
Schizophrenia/Psychosis	
Borderline Personality Disorder	
Obsessive-Compulsive Disorder	
Panic Attacks	
Alcohol Use Disorder/Problem	
Drug Abuse	
Eating Disorder	
Suicide Attempt/Completion	

SUBSTANCE USE HISTORY: (Answer any that apply to you)

Substances	Current Use				Past Use (> 6 months ago)			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Alcohol								
Marijuana								
Cocaine/Stimulants								
Opioids/Heroin								
Sedatives								
Tobacco								
Other								

Substance use treatment history:

_____
_____
_____
_____

Have you had withdrawal symptoms when trying to stop using any substances? If yes, please describe

_____
_____

Have you ever had problems with work, relationships, health, legal, etc. due to your substance use?

_____
_____
_____

Have you gambled in the past 6 months? Yes No

If "yes," Have you ever felt the need to bet more and more money? Yes No

If "yes," Have you ever had to lie to people important to you about how much you gambled? Yes No

Medical Information and History

PRIMARY CARE OR OTHER CLINICIAN(S)(NAME/PHONE):

_____ Date of last physical exam_____Permission to contact _____

CURRENT MEDICAL CONCERNS:_____

_____

_____

_____

MEDICAL HISTORY: (major problems/illnesses, seizures, surgeries, accidents, medical hospitalizations)

_____

_____

_____

FAMILY MEDICAL HISTORY: (major problems/illnesses, seizures, surgeries, accidents, medical hospitalizations)

_____

_____

ALLERGIES:(to any drugs or other allergies)

_____

_____

Review of Systems

Please CHECK any that are or have been a problem for you in the past MONTH: CIRCLE any that are main problems, chronic or particular troublesome:

Constitutional/General
- ☐ Fever
- ☐ Chills
- ☐ Heavy Sweating/Night Sweats
- ☐ Loss of Appetite
- ☐ Sleep Disturbances
- ☐ Unexplained Weight Loss/Gain
- ☐ Other:_____

Eyes
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Wear Glasses
- ☐ Other:_____

Ear/Nose/Throat
- ☐ Sore Throat
- ☐ Mouth Sores
- ☐ Nasal Congestion/Sinus Issues
- ☐ Hearing Loss
- ☐ Other:_____

Respiratory
- ☐ Cough
- ☐ COPD
- ☐ Wheezing
- ☐ Recurrent Upper Respiratory Infections
- ☐ Shortness of Breath
- ☐ Other:_____

Hematologic/Lymphatic
- ☐ Swollen Glands
- ☐ Blood Clotting Problem
- ☐ Easy Bruising
- ☐ Bleeding Tendencies
- ☐ Swollen Glands
- ☐ Other

Cardiovascular
- ☐ Chest Pain or Discomfort
- ☐ Swelling of Feet, Ankles or Legs
- ☐ Irregular Heart Beat
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Palpitations
- ☐ Varicose Veins
- ☐ Other:_____

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Nausea/Vomiting
- ☐ Indigestion or Heartburn
- ☐ Blood in Stools
- ☐ Change in Bowel Habits
- ☐ Rectal Bleeding
- ☐ Diarrhea
- ☐ Constipation
- ☐ Swallowing Difficulties
- ☐ Other:_____

Psychological
- ☐ Depression
- ☐ Anxiety
- ☐ Other:_____

Endocrine
- ☐ Excessive Thirst or Fluid Intake
- ☐ Temperature Intolerance
- ☐ Feeling Tired (Fatigue)
- ☐ Hot Flashes
- ☐ Other:_____

Female Only:
- ☐ ***Pregancies***_____
- ☐ ***Last period***_____

Genitourinary
- ☐ Painful Urination
- ☐ Urinary Frequency
- ☐ Loss of Urinary Control
- ☐ Enlarged Prostate
- ☐ Difficulty Urinating
- ☐ Other:_____

Skin
- ☐ Dry Skin
- ☐ Skin Rash
- ☐ Itching
- ☐ Discoloration of the Skin
- ☐ Lumps or Masses
- ☐ Other:

Musculoskeletal
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Back Pain
- ☐ Limitation of Motion
- ☐ Neck Pain
- ☐ Pain with Walking
- ☐ Other:_____

Neurological
- ☐ Tremors
- ☐ Dizzy Spells
- ☐ Numbness or Tingling
- ☐ Headache
- ☐ Unsteady Gait
- ☐ Feeling Weak
- ☐ Convulsions/Seizure
- ☐ Other

SCL-90

Below is a list of problems that are common. Please read each one carefully and select one of the numbered descriptors that best describes

HOW MUCH THAT PROBLEM HAS BEEN ON YOUR MIND, DISTRESSED OR BOTHERED YOU DURING THE PAST WEEK, INCLUDING TODAY.

Circle the number in the space to the right of the problem and do not skip any items.
IF your answer is:

NOT AT ALL Circle 0
A LITTLE BIT Circle 1
MODERATELY Circle 2
QUITE A BIT Circle 3
EXTREMELY Circle 4

Example: In the previous week, how much were you bothered by:

Faintness or Dizziness 0 (1) 2 3 4

In this case, the person experienced faintness or dizziness "a little bit" (1).

HOW MUCH WERE YOU BOTHERED BY:		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1.	Headaches	0	1	2	3	4
2.	Nervousness or shakiness inside	0	1	2	3	4
3.	Unwanted thoughts, words, or ideas that won't leave your mind	0	1	2	3	4
4.	Faintness or dizziness	0	1	2	3	4
5.	Loss of sexual interest or pleasure	0	1	2	3	4
6.	Feeling critical of others	0	1	2	3	4
7.	The idea that someone else can control your thoughts	0	1	2	3	4
8.	Feeling others are to blame for most of your troubles	0	1	2	3	4
9.	Trouble remembering things	0	1	2	3	4
10.	Worried about sloppiness or carelessness	0	1	2	3	4
11.	Feeling easily annoyed or irritated	0	1	2	3	4
12.	Pains in heart or chest	0	1	2	3	4
13.	Feeling afraid in open spaces or on the streets	0	1	2	3	4
14.	Feeling low in energy or slowed down	0	1	2	3	4
15.	Thoughts of ending your life	0	1	2	3	4
16.	Hearing voices that other people do not hear	0	1	2	3	4
17.	Trembling	0	1	2	3	4

Derogatis LR, Lipman RS, Covi L: "SCL-90" An outpatient psychiatric scale' Preliminary report. Psychopharmacol Bull 9 13-27, 1973

18.	Feeling that most people cannot be trusted	0	1	2	3	4
19.	Poor appetite	0	1	2	3	4

HOW MUCH WERE YOU BOTHERED BY:		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
20.	Crying easily	0	1	2	3	4
21.	Feeling shy or uneasy with the opposite sex	0	1	2	3	4
22.	Feeling of being trapped or caught	0	1	2	3	4
23.	Suddenly scared for no reason	0	1	2	3	4
24.	Temper outbursts that you could not control	0	1	2	3	4
25.	Feeling afraid to go out of your house alone	0	1	2	3	4
26.	Blaming yourself for things	0	1	2	3	4
27.	Pains in lower back	0	1	2	3	4
28.	Feeling blocked in getting things done	0	1	2	3	4
29.	Feeling lonely	0	1	2	3	4
30.	Feeling blue	0	1	2	3	4
31.	Worrying too much about things	0	1	2	3	4
32.	Feeling no interest in things	0	1	2	3	4
33.	Feeling fearful	0	1	2	3	4
34.	Your feelings being easily hurt	0	1	2	3	4
35.	Other people being aware of your private thoughts	0	1	2	3	4
36.	Feeling others do not understand you or are unsympathetic	0	1	2	3	4
37.	Feeling that people are unfriendly or dislike you	0	1	2	3	4
38.	Having to do things very slowly to insure correctness	0	1	2	3	4
39.	Heart pounding or racing	0	1	2	3	4
40.	Nausea or upset stomach	0	1	2	3	4
41.	Feeling inferior to others	0	1	2	3	4
42.	Soreness of your muscles	0	1	2	3	4
43.	Feeling that you are watched or talked about by others	0	1	2	3	4
44.	Trouble falling asleep	0	1	2	3	4
45.	Having to check and double-check what you do	0	1	2	3	4
46.	Difficulty making decisions	0	1	2	3	4
47.	Feeling afraid to travel on buses, subways, trains	0	1	2	3	4

Derogatis LR, Lipman RS, Covi L: "SCL-90" An outpatient psychiatric scale' Preliminary report. Psychopharmacol Bull 9 13-27, 1973

48.	Trouble getting your breath	0	1	2	3	4
49.	Hot or cold spells	0	1	2	3	4
50.	Having to avoid certain things, places, or activities because they frighten you	0	1	2	3	4
51.	Your mind going blank	0	1	2	3	4
52.	Numbness or tingling in parts of your body	0	1	2	3	4
53.	A lump in your throat	0	1	2	3	4
54.	Feeling hopeless about the future	0	1	2	3	4
55.	Trouble concentrating	0	1	2	3	4

HOW MUCH WERE YOU BOTHERED BY:		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
56.	Feeling weak in parts of your body	0	1	2	3	4
57.	Feeling tense or keyed up	0	1	2	3	4
58.	Heavy feelings in your arms or legs	0	1	2	3	4
59.	Thoughts of death or dying	0	1	2	3	4
60.	Overeating	0	1	2	3	4
61.	Feeling uneasy when people are watching or talking about you	0	1	2	3	4
62.	Having thoughts that are not your own	0	1	2	3	4
63.	Having urges to beat, injure, or harm someone	0	1	2	3	4
64.	Awakening in the early morning	0	1	2	3	4
65.	Having to repeat the same actions such as touching, counting, washing	0	1	2	3	4
66.	Sleep that is restless or disturbed	0	1	2	3	4
67.	Having urges to break or smash things	0	1	2	3	4
68.	Having ideas or beliefs that others do not share	0	1	2	3	4
69.	Feeling very self-conscious with others	0	1	2	3	4
70.	Feeling uneasy in crowds, such as shopping or at a movie	0	1	2	3	4
71.	Feeling everything is an effort	0	1	2	3	4
72.	Spells of terror or panic	0	1	2	3	4
73.	Feeling uncomfortable about eating or drinking in public	0	1	2	3	4
74.	Getting into frequent arguments	0	1	2	3	4

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75.	Feeling nervous when you are left alone	0	1	2	3	4
76.	Others not giving you proper credit for your achievements	0	1	2	3	4
77.	Feeling lonely even when you are with people	0	1	2	3	4
78.	Feeling so restless you couldn't sit still	0	1	2	3	4
79.	Feelings of worthlessness	0	1	2	3	4
80.	Feeling that familiar things are strange or unreal	0	1	2	3	4
81.	Shouting or throwing things	0	1	2	3	4
82.	Feeling afraid you will faint in public	0	1	2	3	4
83.	Feeling that people will take advantage of you if you let them	0	1	2	3	4
84.	Having thoughts about sex that bother you a lot	0	1	2	3	4
85.	The idea that you should be punished for your sins	0	1	2	3	4
86.	Feeling pushed to get things done	0	1	2	3	4
87.	The idea that something serious is wrong with your body	0	1	2	3	4
88.	Never feeling close to another person	0	1	2	3	4
89.	Feelings of guilt	0	1	2	3	4
90.	The idea that something is wrong with your mind	0	1	2	3	4

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