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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

Referred by:	
Phone:	Email:

Emergency Contact(s):	
Name:	Phone #:
Name:	Phone #:

Payor/Guarantor:	
Name:	Phone #:

PRESENTING PROBLEM(S)/ REASON FOR SEEKING TREATMENT:

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CURRENT OCCUPATION:
Occupation/Place of Work: ____

Employment Status: ____ Full- time Employed ___Part-time _____Unemployed______Disabled

Workproblems/Stressors:____

____

EDUCATION LEVEL: (Please list highest education level attained or degrees):

____

RELATIONSHIPS:

Marriages/Cohabiting partners:____
Children:____

Religious/Spiritual orientation if any

____

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if you answer Yes, please explain):

____

PSYCHIATRIC HISTORY: Hospitalizations, Psychotherapy or other Psychiatric treatments: specify: month year(s), beginning—end, estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Individual/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended and any suicide attempts or plans or history of self-harm:

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<u>SUBSTANCE USE:</u> (past/present drug or alcohol use/problem/treatment)

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<u>FAMILY PSYCHIATRIC HISTORY</u>: (**including suicide, depression, hospitalizations, etc**.)

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<u>FAMILY MEDICAL HISTORY</u>:____

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

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Primary Care or other clinician(s)(name/phone):

____Permission to contact _____

Allergies to any drugs or other allergies (please list):

____

<u>MEDICATIONS or OVER THE COUNTER/HERBAL/SUPPLEMENTS</u> you are presently taking and for what.

(*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

Medical 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

Psychiatric Symptom Checklist

Please check off all that apply.

1 (never) -- 5 (often/daily)

Depression	**1 (never) – 5 (often)**
1. Do you feel sad or empty or do others think you are sad?	❑ ❑ ❑ ❑ ❑
2. Do you find yourself crying for no reason?	❑ ❑ ❑ ❑ ❑
3. Do you feel heavy inside?	❑ ❑ ❑ ❑ ❑
4. Have you lost or gained a lot of weight recently?	❑ ❑ ❑ ❑ ❑
5. Do you have a hard time falling asleep?	❑ ❑ ❑ ❑ ❑
6. Do you have a hard time staying asleep?	❑ ❑ ❑ ❑ ❑
7. Do you wake up rested?	❑ ❑ ❑ ❑ ❑
8. Do you or other people comment that you are always on the move, agitated or restless?	❑ ❑ ❑ ❑ ❑
9. Do you feel fatigued or have loss of energy nearly every day?	❑ ❑ ❑ ❑ ❑
10. Do you feel an inappropriate sense of guilt for things in the past?	❑ ❑ ❑ ❑ ❑
11. Do you feel that you don't have anything to look forward to?	❑ ❑ ❑ ❑ ❑
12. Do you have difficulty concentrating or making decisions?	❑ ❑ ❑ ❑ ❑
13. Do you find yourself with little or no pleasure in things that you think should give you pleasure?	❑ ❑ ❑ ❑ ❑
How would your rate your overall mood most days:	
1. Do you have persistent elevated, expansive or irritable mood?	❑ ❑ ❑ ❑ ❑
2. Do you have a lot of energy after getting very little sleep?	❑ ❑ ❑ ❑ ❑
3. Do you have a lot of energy that is hard to contain or control?	❑ ❑ ❑ ❑ ❑
4. Do you feel on top of the world, better than other people; that nothing can get to you?	❑ ❑ ❑ ❑ ❑
5. Do you feel rested after only 3 hours of sleep?	❑ ❑ ❑ ❑ ❑
6. Do you have racing thoughts or does it feel as though your thoughts sometimes run away from you?	❑ ❑ ❑ ❑ ❑
7. Do you take on a lot of projects at once?	❑ ❑ ❑ ❑ ❑
8. Do you go on buying sprees for things you don't need and/or don't have the money for but buy anyway?	❑ ❑ ❑ ❑ ❑
9. Do you do things that you or others think are risky but you feel driven to do them anyway?	❑ ❑ ❑ ❑ ❑
Anxiety & Panic	**1 (never) – 5 (often)**
1. Does your heart race or pound really hard?	❑ ❑ ❑ ❑ ❑
2. Do you find yourself sweating without having done something overly physical?	❑ ❑ ❑ ❑ ❑
3. Do you shake or tremble for no apparent reason?	❑ ❑ ❑ ❑ ❑
4. Do you feel short of breath or have the feeling you can't breathe?	❑ ❑ ❑ ❑ ❑
5. Do you feel like you have a lump in your throat or like you're chocking?	❑ ❑ ❑ ❑ ❑
6. Do you have chest pain, get nauseous or have butterflies in your stomach for no medical reason?	❑ ❑ ❑ ❑ ❑
7. Do you feel dizzy, unsteady, lightheaded or like you're going to faint?	❑ ❑ ❑ ❑ ❑
8. Do you feel like you're floating above yourself looking down at what's happening?	❑ ❑ ❑ ❑ ❑
9. Does it feel like you're looking at life through a gauze?	❑ ❑ ❑ ❑ ❑
10. Do your hands or feet ever feel numb with no medical reason?	❑ ❑ ❑ ❑ ❑
11. Do you get chills or hot flashes?	❑ ❑ ❑ ❑ ❑
12. Do you worry about having a panic attack?	❑ ❑ ❑ ❑ ❑
13. Does the fear of having a panic attack keep you from going out?	❑ ❑ ❑ ❑ ❑
How would you rate your overall anxiety?	
1. Do you have a difficult time going out of the house, taking public transportation, crossing bridges, riding in elevators, etc.?	❑ ❑ ❑ ❑ ❑
2. Does the thought of going out in public make you panic?	❑ ❑ ❑ ❑ ❑
3. When you're on public transportation, in an elevator or at a restaurant, do you need to be near the door?	❑ ❑ ❑ ❑ ❑

4. When in public, are you on the look-out for something bad to happen if you don’t stay alert?	❑ ❑ ❑ ❑ ❑
5. Do you need or prefer that someone to go with you when you leave the house?	❑ ❑ ❑ ❑ ❑
Obsessions & Compulsions	**1 (never) – 5 (often)**
1. Do you have repetitive thoughts you can’t put out of your mind?	❑ ❑ ❑ ❑ ❑
2. Do you engage in rituals or feel driven to do things like constant checking whether the stove is turned off, the door is closed, hand washing, praying, counting, or repeating words silently?	❑ ❑ ❑ ❑ ❑
3. Do you find that doing these activities prevent or relieve distressing thoughts or feelings?	❑ ❑ ❑ ❑ ❑
4. Do you need to allow yourself extra time to leave the house because of checking or the rituals?	❑ ❑ ❑ ❑ ❑
5. Even though you go through these rituals, you are still distressed, upset, or anxious?	❑ ❑ ❑ ❑ ❑
Trauma	**1 (never) – 5 (often)**
1. Has anyone hurt or touched you in ways you didn’t want or have you witnessed someone being hurt?	❑ ❑ ❑ ❑ ❑
2. Do you have flashbacks, nightmares or recurring dreams from what happened during of past events?	❑ ❑ ❑ ❑ ❑
3. Do you try to avoid feeling, thinking or talking about events from the past that bother you?	❑ ❑ ❑ ❑ ❑
4. Are there people, places or things you avoid because they remind you of the past?	❑ ❑ ❑ ❑ ❑
5. Do you feel emotionally numb, as though you have no feelings or response to things that you “should” respond to?	❑ ❑ ❑ ❑ ❑
6. Do you have angry outbursts that can’t be controlled?	❑ ❑ ❑ ❑ ❑
7. If someone tapped you on the shoulder from behind, would you be highly startled or surprised?	❑ ❑ ❑ ❑ ❑
8. Did you lose a parent or caretaker before the age of 21?	❑ ❑ ❑ ❑ ❑
Dissociation/Disorientation/Psychosis	**1 (seldom) – 5 (often)**
1. Do you have behaviors or thoughts that are strange or odd?	❑ ❑ ❑ ❑ ❑
2. Do people insist they know you even though you don’t recognize them?	❑ ❑ ❑ ❑ ❑
3. Do you find yourself in places and you don’t remember how you got there?	❑ ❑ ❑ ❑ ❑
4. Do you feel as if you are looking at the world through a fog so that people and objects appear far away or unclear or like you are living in a movie and watching yourself?	❑ ❑ ❑ ❑ ❑
5. Do you find things in your possession that you don’t remember purchasing?	❑ ❑ ❑ ❑ ❑
6. Do people say you did something even though you don’t remember doing it?	❑ ❑ ❑ ❑ ❑
7. Does time go by and you don’t remember what happened?	❑ ❑ ❑ ❑ ❑
8. Do you hear voices or see things others don’t?	❑ ❑ ❑ ❑ ❑
9. Do you habitually feel or think that people are out to harm you?	❑ ❑ ❑ ❑ ❑
Alcohol & Drugs	**1 (never) – 5 (often)**
1. Has your alcohol/drug use stopped you from going to work, doing things around the house or going out socially?	❑ ❑ ❑ ❑ ❑
2. Do you use alcohol or drugs even though you know that it makes you depressed?	❑ ❑ ❑ ❑ ❑
3. Do you find yourself drinking/using drugs even though you have an ulcer/are on kidney dialysis?	❑ ❑ ❑ ❑ ❑
4. Have you ever gotten into work or legal problems because of your drinking / drug use?	❑ ❑ ❑ ❑ ❑
5. Do other people think that you drink too much or have a drug problem?	❑ ❑ ❑ ❑ ❑
6. Do you find yourself getting into fights with people or saying things you wish you hadn’t said when you’re drinking/using drugs?	❑ ❑ ❑ ❑ ❑
7. Do you find you need more to get the same high as you used to get?	❑ ❑ ❑ ❑ ❑
8. Do you find yourself wanting to stop or cut down but can’t?	❑ ❑ ❑ ❑ ❑
Food & Body Image	**1 (never) – 5 (often)**
1. Do you eat a large amount of food in a short amount of time; more food than others usually eat?	❑ ❑ ❑ ❑ ❑
2. Do you restrict what you eat or feel like you yo-yo diet?	❑ ❑ ❑ ❑ ❑
3. Do you purge or deliberately thrown up after eating or use laxatives to maintain your weight?	❑ ❑ ❑ ❑ ❑
4. Do you feel out of control when you eat or have a feeling that you cannot stop?	❑ ❑ ❑ ❑ ❑
5. Do you feel ashamed, disgusted or guilty after eating or have an intense fear of gaining weight?	❑ ❑ ❑ ❑ ❑