New Patient Intake Form

Please complete all information on this form and bring to your first visit, along with any recent lab results and the bottle or a detailed list of all prescribed and over the counter medication you are taking. If you are unable to complete it at home, please come 30-minutes prior to your scheduled appointment time to fill out in the office. You may need to ask family members about the family history. Thank you!

Personal Information

Name:____Today's Date:__________________________

Parent/Legal Guardian (if under 18):____

Address:______________________City:__________________State___________Zip Code_______________

Date of Birth:__________________________Age:__________________Gender at Birth:________________

SSN:____

Gender Identified as (circle one): Male, Female, Trans Male/Trans Man, Trans Female/Trans Woman, Genderqueer/Gender Non-Conforming, Different Identity:

Sexual Orientation (circle more): Heterosexual or Straight, Gay, Lesbian, Bisexual

Not listed above (please specify):________________________________

Phone:___________________________________May we leave a message? □ Yes □ No

Email: ____ May we leave a message? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Marital Status:

□ Never Married □ Domestic Partnership □ Married

□ Separated □ Divorced □ Widowed

Number of children ____________________Children's Names & Ages:_____________________________________
____

Are you currently employed? _________If yes, please indicate your job title/description:_______________________
____

Do you enjoy your work? Is there anything stressful about your current work?

Are you currently in school? □ Yes □ No If yes, name of school and grade or degree program:___________________

Do you have a learning disability, every missed a developmental milestone, been placed in a special needs class or been diagnosed with a mental/developmental disability? □ No □ Yes, If yes please list:_________________________

Highest grade completed or degree received:____

Primary Care Provider:___________________________Phone: ____________Fax:__________________________

History

Have you ever received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes

Have you ever been diagnosed with any psychiatric issues? □ Yes□ No, If yes, please list diagnoses and when (age/year) you were diagnosed:____

Are you currently taking, or have you ever been prescribed psychiatric medication? □ Yes□ No, If yes, please list medication, dosage and how long you have been taking medication.

Are you currently seeing a therapist, or have you seen one before? □ Yes□ No, If yes, please list therapist name and last time you were seen:____

Current Therapist Phone:______________________________Fax:____

Have you ever been hospitalized for mental health issues? □ No □ Yes, If yes, please list reason for hospitalization and dates?

Do you have any medical issue (ex: high blood pressure, diabetes, etc.)? □ Yes□ No, If yes, please list:____________

Are you currently taking any prescription or over the counter medications? □ Yes□ No, If yes, please list.

Surgical History:

Allergies:

History of seizures? □ No □ Yes, If yes when was your last seizure?______________________________________

For women only:

Date of last menstrual period ________ Are you currently pregnant or think you might be pregnant? □ No □ Yes
Are you planning to get pregnant in the near future? □ No □ Yes; Have you had a hysterectomy? □ No □ Yes

Birth control method __________________________

How many times have you been pregnant? ________ How many live births? ________

General and Mental Health Information

Current Symptoms (circle all that apply):

Fatigue or Lack of Energy	Decreased Interest in Activities
Excessive Guilt	Depressed or Sad
Mood Swings	Weight Changes
Appetite Change	Poor Concentration
Worthlessness	Decreased Libido
Hopelessness	Hallucinations/Hearing or Seeing Thing Not There
Panic Attacks	Decrease or Increased Sleep Pattern
Low self-esteem	Suspiciousness
Low Motivation	Excessive Energy
Excessive Worry	Irritability
Tearful/Crying	Anger
Suicidal/Homicidal Thoughts	Increased Energy/ Not needing Sleep

Other: ____

Are you current having suicidal or homicidal thoughts? □ No □ Yes If yes, please describe:___________________
____

Please describe any past suicidal or homicidal thoughts, plans, or actions/attempts (If not applicable to you, please write N/A):____
____

Have you ever been the victim of or witness to trauma or abuse? □ No □ Yes If yes, please describe below. (ex: instances of sexual, emotional, physical abuse or neglect and/or being a victim of an accident, violent crime, or a natural disaster.)____
____
____

How would you rate your current physical health? (Please circle one): Poor, Good, Very Good

Are you currently experiencing any chronic pain? □ No □ Yes If yes, please describe:

____

Tobacco History:

How you ever smoked cigarettes? □ No □ Yes

Currently Smoke? □ No □ Yes, If yes, how many packs per day on average? ______How many years? _________

In the past, how many years did you smoke? ________ When did you quit? _____________

Pipe, cigars, vapor, e-cigarettes, chew tobacco, snuff/dip: Current use? □ No □ Yes; Used in the past? □ No □ Yes

What kind? ___________________ How often per day on average? ______ How many years? ____________

Do you drink alcohol more than once a week? □ No □ Yes If yes, please list type of alcohol, how many days per week you drink and how many drinks you have per day:

____

How often do you engage in recreational drug use? □ Daily□ Weekly □ Monthly □ Infrequently □ Never; If you do what type of drug (circle all that apply)? Marijuana, Cocaine, Heroin, Meth, Other:_____________________________

____

How would you rate your current sleeping habits? (Please circle one) Poor, Good, Very good; How many hours do you sleep at night?_____________________

Please list any specific sleep problems you are currently experiencing:

____

Please list any difficulties you experience with your appetite or eating problems (put N/A if none):

____

Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long?____

Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this and what symptoms are you having?

____

____

Family History

Please Circle Yes or No	**Family Member's Relation to You**
Alcohol/Substance Abuse yes / no	______________________________
Anxiety yes / no	______________________________
Depression yes / no	______________________________
Domestic Violence yes / no	______________________________
Eating Disorders yes / no	______________________________
Obesity yes / no	______________________________
Obsessive Compulsive Behavior yes / no	______________________________
Bipolar Disorder yes/no	______________________________

Schizophrenia yes / no ______________________________

Suicide Attempts yes / no ______________________________

Completed Suicide yes/no ______________________________

Have you ever had any legal issues? □ No □ Yes, If yes what type?____
____

Do you consider yourself to be spiritual or religious? □ No □ Yes If yes, describe your faith or belief:

____
____

What do you consider to be some of your strengths?

____
____

What do you consider to be some of your weaknesses?

____
____

What brought you into seek therapy?

____
____

What would you like to accomplish out of your time in therapy?

____
____

____

Client/Guardian Printed Name

______________________________________ ______________________________

Client/Guardian Signature Date