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New Patient Intake Form

Name: _____

Date: _____

Address: _____

_____

Home Phone: _____ Okay to leave a message? ☐Yes ☐No

Cell Phone: _____ Okay to leave a message? ☐Yes ☐No

Email: _____

Date of Birth: _____

Place of Birth: _____

Religious Affiliation / Preference: _____

Marital Status: _____

Do you have children? ☐Yes ☐No

If yes, please tell me how many and their ages / gender:

_____

_____

Allergies: _____

Any Medical Conditions? (If yes, please explain in as much detail as you can):

_____

_____

List Current Medications:

_____

_____

Current Primary Physician: _____

Are you currently seeing any other specialists? (If yes, please list):

_____

_____

Have you ever received any type of psychotherapeutic services before? ☐Yes ☐No

If yes, please list the date and type of last service: _____

Please give a brief description of what brings you to seek treatment at this time:

_____

_____

New Patient Intake Form

Please check all that apply to you:

- ☐ 1. Concerned about my eating habits
- ☐ 2. Concerned about my drinking, smoking or drug use
- ☐ 3. Not adjusting well to a new situation
- ☐ 4. Have difficulty trusting other people
- ☐ 5. Do not get along with parents or family members
- ☐ 6. Cannot seem to control my thoughts or behavior
- ☐ 7. Feeling depressed or unhappy
- ☐ 8. Have headaches, indigestion or other physical problems
- ☐ 9. Thinking about killing myself
- ☐ 10. Anxious or nervous much of the time
- ☐ 11. Have fears that seem unrealistic
- ☐ 12. Concerned about past physical or sexual abuse
- ☐ 13. Bothered by insomnia
- ☐ 14. Concerned about parent's drinking
- ☐ 15. Worried about a sexual issue
- ☐ 16. Wishing I could be different
- ☐ 17. Having trouble with work or studies
- ☐ 18. Upset by a recent death
- ☐ 19. Concerned about my primary relationship
- ☐ 20. Feel tired, dizzy and/or weak much of the time
- ☐ 21. Dealing with my sexual orientation
- ☐ 22. Concerned about my weight
- ☐ 23. Many of my activities include alcohol and/or drugs
- ☐ 24. Easily moved to tears
- ☐ 25. Concerned about personal experience of sexual/racial harassment
- ☐ 26. Getting a divorce
- ☐ 27. Unsure of my future plans

Emergency Contact (Name and Phone Number):

_____

Relationship to You: _____

Please be advised that I do not participate with any insurance providers. However, on occasion it is helpful for me to call your carrier to help you receive reimbursement for mental health services. If you ask me to call your insurance carrier, some personal identifying information may be requested. Please sign below to indicate that you consent to my sharing personal identifying information with your insurance company for the express reason of aiding in your reimbursement:

Signature: _____

Date: _____

Thank you for answering the above questions as completely as you can.