

INTAKE INFORMATION

Name: _____	Date: _____
Address: _____	Birth Date: _____
City: _____ State: _____ Zip: _____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F Age: _____
Referral Source: _____	

Contact Information

Home: () _____	Okay to leave messages?
Work: () _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cell: () _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
Emergency Contact Name: _____	Phone () _____ Relationship: _____

Insurance Information

Primary Insurance Co: _____	Ins Phone #: () _____
Insurance Co. Address: _____	City/State/Zip: _____
ID #: _____	Group #: _____ Copay Amt: _____
Policyholder Name: _____	Relationship to client: _____
Policyholder's Address: _____	City: _____ State: _____ Zip: _____
Policyholder's Birthdate: _____	Phone #: _____ Soc Sec #: _____
Policyholder's Place of Employment: _____	

Marital/Family Information

<input type="checkbox"/> Never Married <input type="checkbox"/> Married (____ yrs) <input type="checkbox"/> Living together (____ yrs) <input type="checkbox"/> Separated (____ yrs)
<input type="checkbox"/> Divorced (____ yrs) <input type="checkbox"/> Widowed (____ yrs)
If I am unable to reach you, is it OK to contact your spouse/partner? <input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, spouse/partner's name and phone number: _____
Others living in the home (include names, ages, & relationship to client): _____

Employment/Education

Current Employer: _____	Position: _____
Part time <input type="checkbox"/> Full Time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed	Other jobs held: _____
Are you currently in school? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Part Time <input type="checkbox"/> Full Area of study: _____
Degree/Vocation _____	Highest grade level completed: _____

Medical

Physician's Name: _____	Phone: () _____
Address: _____	Fax No:() _____
List any current health problems & medications: _____	

Religious/Spiritual

What is your spiritual or religious affiliation? _____
How important is religious commitment? <input type="checkbox"/> Very Important <input type="checkbox"/> Somewhat <input type="checkbox"/> Not Important

Dx code _____ (for clinician only)

Legal Problems

Are you currently involved in criminal procedures? Yes No

If yes, please explain: _____

Counseling History

Do you have a history of mental health treatment? YES NO If yes, provide dates, name of provider, and reason for treatment: _____

Have you ever been hospitalized for psychiatric reasons? Yes No

If yes, please explain: _____

Have you ever had thoughts, made statements, attempted to hurt yourself? Yes No

If yes, please explain: _____

Have you ever had thoughts, made statements, attempted to hurt someone else? Yes No

If yes, please explain: _____

Have you recently been physically hurt or threatened by someone else? Yes No

If yes, please explain: _____

Have you ever been treated for a drug and/or alcohol abuse? Yes No

If yes, please explain: _____

Has a family member or friend expressed concern about your substance use? Yes No

If yes, please explain: _____

Reason for Treatment/Current Symptoms

What are the reasons for this visit? _____

How long have you had this problem? _____

What have you done to try to resolve this problem? _____

On a 1 to 10 scale (10=worst, 1= best), rate your current level of distress? _____

What do you hope to accomplish in treatment? _____

Please check all symptoms/problems that have been of concern to you in the past 2 weeks.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Anxious mood | <input type="checkbox"/> Excessive talking | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Low self worth | <input type="checkbox"/> Muscle tension | <input type="checkbox"/> Irritable/angry mood | <input type="checkbox"/> Gambling problems |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Excessive worries | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Relationship problems |
| <input type="checkbox"/> Loss of pleasure | <input type="checkbox"/> Phobias | <input type="checkbox"/> Impulsive behavior | <input type="checkbox"/> Grief/loss |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Rapid heart rate | <input type="checkbox"/> Disorganized thought | <input type="checkbox"/> Food restriction |
| <input type="checkbox"/> Thoughts of dying | <input type="checkbox"/> Social avoidance | <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Food binge/purge |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Tremors | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Domestic violence |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Restlessness | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Sleeping too much | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Homicidal thoughts |
| <input type="checkbox"/> Weight changes | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Visual hallucinations | <input type="checkbox"/> Family problems |
| <input type="checkbox"/> Helplessness | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Marital problems |
| <input type="checkbox"/> Other relevant information: _____ | | | |