Confidential Patient Intake Form

Name .....

Address .....

Phone .....

May I leave a message for you at this number? .....

Cell Phone .....

Local Emergency Contact, Name and Phone Number: .....

.....

Email .....

I would like to receive monthly email newsletters with wellness tips and special offers.
Please circle: YES or NO

Parent or Guardian if you are under 18 .....

Please circle:

Married Never Married Domestic Partnership Separated Divorced Widowed

Currently in a romantic relationship Length of time on any of the above .....

Please list preferred form of communication .....

Employer .....

Date of Birth (month, day and year) .....

Gender .....

Children, please list with age .....

.....

Who were you referred by .....

Have you been in therapy before

Please list the last mental health professional you saw

Please list any medications you are currently taking

Please list any health problems you currently have

Do you smoke

Do you drink alcohol

Do you engage in recreational drug use (how often)

Have you ever taken psychiatric medication?

Please list the psychiatric medication with dates

Are you religious or spiritual (please state faith or belief)

Current state of physical health

Do you have any current health issues

Do you have sleep problems

How often do you exercise

What type of exercise

Are you experiencing problems with eating or loss /gain in appetite

Are you currently depressed

Have you recently experienced a death of a loved one (how long ago)

Do you have panic attacks

Do you have any phobias

Do you have chronic pain

Date pain started and how often

Have you recently experienced a stressful life event

Please list a family member for the any of the following:

Alcohol and or substance abuse

Anxiety

Depression

Domestic violence

Eating disorders

Obesity

Obsessive compulsive behavior

Schizophrenia

Suicide or attempts

What would you like to get out of therapy or your reason for seeking therapy

Are you currently experiencing thoughts of harming yourself or someone else. If yes, please explain.

Cancellation Policy

We must be notified 24 hours in advance of a cancellation. If you do not notify us within 24 hours of your scheduled appointment you will be billed for your appointment. Please note if you miss your appointment due to an emergency you will not be billed.

Signature

.....

Date

.....