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Patient Intake Form

Today's Date: _____

Personal Information

Patient's name: _____ Date of Birth: _____

Address:

_____

Street Apt #

_____ SELECT ONE: _____

City State Zip code

Primary phone: _____ Email: _____

Employer or school name: _____

Highest level of education completed or current grade/major/field: _____

Emergency contact name: _____ Relationship: _____

Emergency contact phone: _____

Referral's name: _____ Relationship: _____

Are you currently covered by Medicaid or Medicare?: SELECT ONE:

Family Information

Marital status: SELECT ONE:

Dates of marriage, divorce, death of spouse, etc.:

_____

People currently living in household (names/ages/relationships):

_____

_____

Current partner name (if relevant): _____ Age: _____

History of relevant family events/stressors (e.g., adoptions, divorces, deaths, substance abuse):

_____

_____

_____

Biological family history of psychological issues (e.g., ADHD in sibling, bipolar disorder in uncle):

_____

_____

Medical Information

Physician's name: _____ Phone: _____

Reason for most recent visit: _____ Date of visit: _____

Current medical condition(s):

_____

_____

_____

Current medications (name, dose, frequency):

_____

_____

_____

Lifestyle Information

Current alcohol or drug use (type/frequency/duration at such frequency):

_____

_____

Previous alcohol or drug use (type/frequency/duration at such frequency):

_____

_____

Primary Concerns

Briefly describe the problems or concerns that bring you here today:

_____

_____

_____

_____

_____

_____

Previous Services

List previous therapies, treatment, tutoring, academic accommodations, hospitalizations, etc. (including any substance use treatment).

Therapist's name/agency/hospital:	Dates or ages when received:
_____	_____
_____	_____
_____	_____
_____	_____

Your signature below indicates that you consent to treatment *(see more details in Patient Services Agreement).*

Patient's printed name: _____

Patient's signature: _____ Date: _____