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## Patient Intake Form

Today's date \_\_\_\_\_

### Personal Information

Patient's name \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_

Street \_\_\_\_\_ Apt # \_\_\_\_\_

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 \_\_\_\_\_

Is the patient currently covered by Medicaid or Medicare? \_\_\_\_\_

### Family Information

Marital status:

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):

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

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**Medical Information**

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

Psychiatrist's name \_\_\_\_\_ Phone \_\_\_\_\_

Reason for most recent visit \_\_\_\_\_ Date of visit \_\_\_\_\_

Current medical condition(s) \_\_\_\_\_

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Current medications (name, dose, frequency) \_\_\_\_\_

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**Lifestyle Information**

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

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

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**Primary Concerns**

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

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**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

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

Patient's printed name \_\_\_\_\_

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_