**Intake Form**

**PURPOSE:** The purpose of this document is to provide information regarding the patient’s history that may aid in assessment, treatment planning, and treatment. The completion of this document may reduce the amount of time required for the initial assessment and evaluation of the patient. The information provided in this document is considered Protected Health Information (PHI) and will be managed according to current HIPPA guidelines and state and local laws. For additional information regarding the limits of confidentiality and management of PHI, please refer to the HIPPA Notice of Privacy Practices and Outpatient Service Contract forms.

**Please leave blank any question you do not understand or would rather not answer.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name |  | DOB |  | Age |  |
| Nickname: |  | Preferred Language |  |
| Legal Guardian (Under 18) |  | Custody Arrangement |  |
| Legal Guardian (Under 18) |  | Custody Arrangement |  |
| Marital Status |  | Race/Ethnicity |  |
| Sex |  | Gender |  |
| Address |  | Apt |  | City |  | Zip |  |
| Home Phone |  | May We Leave a Message (Y/N) |  |
| Cell Phone |  | May We Leave a Message (Y/N) |  |
| Email |  |
| Emergency Contact Name |  |
| Relationship |  | Contact Number |  |
| Referred By |  |

\**Please note: Email correspondence is not considered to be a confidential medium of communication (see informed consent).*

**Current Symptoms**

*Reason for Seeking Treatment:*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Symptoms |  Yes/No | When Did It Start? | How Often Does It Occur? | Severity (1-10) |
| Sadness |  |  |  |  |
| Hopelessness/Helplessness |  |  |  |  |
| Grief |  |  |  |  |
| Anxiety |  |  |  |  |
| Panic Attacks |  |  |  |  |
| Phobias |  |  |  |  |
| Hallucinations |  |  |  |  |
| Delusions |  |  |  |  |
| Anger |  |  |  |  |
| Sleep Problems |  |  |  |  |
| Gambling Problems |  |  |  |  |
| Excessive Energy |  |  |  |  |
| Obsessions/Compulsions |  |  |  |  |
| Eating Problems |  |  |  |  |
| Chronic Pain |  |  |  |  |
| Other: |  |  |  |  |
| Other: |  |  |  |  |

What are your treatment expectations?

*Safety*

|  |  |
| --- | --- |
| Do you have any thoughts of killing yourself? (Yes/No) |  |
| If so, Why? | Plan? (Describe) | Have you made preparations? |
|  |  |  |
| Have you ever thought of killing yourself in the past? (Yes/No) |  |
| If so, When? | Why? | Plan? (Describe) | Did you make an attempt to hurt/kill self? |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Do you have thoughts of intentionally hurting yourself right now? (Yes/No) |  |
| If so, Why? | Plan? (Describe) | Do you have the means? |
|  |  |  |
| Have you ever intentionally hurt yourself? (Yes/No) |  |
| If so, When? | Why? | What did you do to hurt yourself? | Did you Require Medical Attention? |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |
| Do you have thoughts of hurting another individual right now? (Yes/No) |  |
| Why? | Plan? (Describe) | Do you think you will follow through with the plan? |
|  |  |  |
| Have you ever thought of hurting or killing another individual? (Yes/No) |  |
| If so, When? | Why? | Plan? (Describe) | Did you make an attempt to hurt/kill self? |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Do you have access to weapons/firearms/sharp objects? (Describe) |  |
| Do you feel safe in your current residence?  |
| (If yes, please describe) |
| Is anybody currently Physically, Sexually, or Emotionally Abusing you? Or are you currently being Neglected? |
| (If yes, please describe) |
| Have you ever been physically abused? (Yes/No) |  |
| If yes, When? | By whom? (relationship) | Do you still have contact with the perpetrator? |
|  |  |  |
|  |  |  |
| Have you ever been emotionally abused? (Yes/No) |  |
| If yes, When? | By whom? (relationship) | Do you still have contact with the perpetrator? |
|  |  |  |
|  |  |  |
| Have you ever been sexually abused? (Yes/No) |  |
| If yes, When? | By whom? (relationship) | Do you still have contact with the perpetrator? |
|  |  |  |
|  |  |  |

*Substance Abuse*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Substance | Date of First Use | Date of Most Recent Use | Frequency(per day/week) | Amount Used | Negative Effects |
| Alcohol |  |  |  |  |  |
| Marijuana |  |  |  |  |  |
| Caffeine |  |  |  |  |  |
| Tobacco/Nicotine |  |  |  |  |  |
| Methamphetamine/Stimulants |  |  |  |  |  |
| Opioids/Heroine |  |  |  |  |  |
| Cocaine |  |  |  |  |  |
| Hallucinogens |  |  |  |  |  |
| Inhalants |  |  |  |  |  |
| Prescription Meds |  |  |  |  |  |
| Other: |  |  |  |  |  |
| Other: |  |  |  |  |  |
| Have you ever experienced a time where you or somebody else thought you had a problem with alcohol/drugs? (Yes/No) |  |
| Have you ever felt guilty after using drugs/alcohol? |  |
| Have you ever experienced a time where you stopped using drugs/alcohol for a period of time and then started using again? (Yes/No) |  |
| If so, please describe |  |
| Have you ever participated in treatment for alcohol/drugs? (Yes/No) |  |
| If so, when, where, did you graduate, and was it helpful? |  |

*Behavioral Problems (Please complete if under age 18)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Behavior | History (Y/N) | Current (Y/N) | Behavior | History (Y/N) | Current (Y/N) |
| Fighting |  |  | Setting Fires |  |  |
| Attention Problems |  |  | Property Damage |  |  |
| Stealing |  |  | Hurting Animals |  |  |
| Lying |  |  | Yelling/Threatening |  |  |
| Not Following Rules/Instructions |  |  | Repetitive Behaviors |  |  |
| Inappropriate Sexual Behaviors |  |  | Social Problems |  |  |
| Other: |  |  | Other: |  |  |

**Medical**

*General Medical Information*

|  |  |
| --- | --- |
| Do you have any general medical concerns/problems? (Yes/No) |  |
| If yes, please describe |  |
| Do you have any chronic medical conditions? (Yes/No) |  |
| If yes, please list |  |
| Do you visit a physician on a regular basis? (Yes/No) |  |
| Do you have any problems with hearing? (Yes/No) (Describe) |  |
| Do you have any problems with vision? (Yes/No) (Describe) |  |
| Do you have any allergies? (Yes/No) (List) |  |
| Have you experienced any injury to the head/brain? (Yes/No) |  |
| If Yes, please describe |  |
| Current Medications (Prescribed and Over the Counter) |
| Name | Dosage | Date First Prescribed | Prescribed By |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Background Information**

*Developmental History*

|  |  |
| --- | --- |
| Was there any prenatal exposure to drugs or alcohol? (Yes/No) |  |
| If yes, please describe? |  |
| Were there any delays in the patient/child’s developmental abilities (i.e. walking, talking, language, toilet training, etc?” (Yes/No): |
| If so, please describe (specific delay and age): |  |

*Family History*

|  |  |
| --- | --- |
| How many people are in the family? (Relationships and Age): |  |
| Is the residence safe from violence, substance use, domestic violence, neglect, basic necessities, etc.) (Yes/No): |
| If no, please describe: |  |
| Have any family members been diagnosed with a mental health or developmental disorder? (Yes/No) |  |
| If yes, please list: |  |
| Do any members use drugs, alcohol, or misuse prescription/non prescription pills? (Yes/No) |  |
| If yes, please list: |  |
| Do any family members have chronic medical problems? (Yes/No) |  |
| If yes, please list: |  |
| Has there been any domestic violence or abuse (physical, sexual, emotional) in the family? |  |
| If yes, please describe: |  |
| Has the family been involved with Child Welfare or Child Protective Services? (Yes/No) |  |
| If yes, please describe: |  |
| Has there been any significant emotional losses/changes in the family? (Yes/No) |  |
| If yes, please describe: |  |
| What are the current strengths in the family? |  |
| What are the current family stressors? |  |

*Mental Health History*

|  |  |
| --- | --- |
| Has the patient ever participated in therapy before? (Yes/No) |  |
| If so, Dates | Place | Mental Health Provider | Reason | Helpful? (Y/N) |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| Has the patient been prescribed medication for mental health reasons? (Yes/No) |  |
| If so, Dates | Place | Prescribing Physician | Reasons | Helpful? (Y/N) |
|  |  |  |  |  |
|  |  |  |  |  |
| Has the patient been hospitalized for mental health reasons in the past (Yes/No) |  |
| If so, Dates | Place | Reasons |
|  |  |  |
|  |  |  |
| Has the patient ever been diagnosed with a mental health diagnosis (Yes/No) |  |
| If so, Date | Diagnosis | By Whom? |
|  |  |  |
|  |  |  |
|  |  |  |

*School and Employment History*

|  |  |  |  |
| --- | --- | --- | --- |
| Last grade completed? |  | Highest degree earned? |  |
| Has the patient repeated any grades? (Yes/No) |  | What grades? |  |
| Did the patient experience any behavioral problems in school? (Yes/No) |  |
| If so, please describe? |  |
| Has the patient ever been suspended or expelled from school? (Yes/No) |  |
| If so, please describe? |  |
| Has the patient ever participated in special education classes (IEP)? (Yes/No) |  |
| If so, for what? |  |
| Is the patient currently employed? (Yes/No) |  | Full Time/Part Time? |  |
| Most Recent Place of Employment (Name/Pos): |  |
| Spouse/Partner’s Most Recent Place Employment (Name/Pos): |  |
| Have you been/are you a member of the Armed Forces? (Yes/No) |  | Branch? |  |

*Additional Psychosocial Information*

|  |  |
| --- | --- |
| Has the patient ever been arrested, charged, or convicted of a crime? (Yes/No) |  |
| If so, please describe date and charge: |  |
| Is the patient currently on probation or parole? (Yes/No) |  |
| If so, Name | Contact Information | End Date |
|  |
| Please list patient’s preferred leisure activities? |  |
| Please list patient’s strengths? |  |
| Anything else you would like us to take into account when working with the patient/family? |
| Please list |  |