Pre-Intake Form

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| **Name** | | **Date** |
| **Age** | | **Date of Birth** |
| **Street** | | **Suite/Apt. #** |
| **City** | **State** | **ZIP code** |
| **Email Address** | | |
| **Phone (home)**  **Is it ok to leave messages at this number?** | **Phone (work)**  **Is it ok to leave messages at this number?** | |
| **Name of person with whom you live** | | **Relationship** |
| **Name of person to call**  **in an emergency** | | **Relationship** |
| **Street** | | **Suite/Apt. #** |
| **City** | | **State** |
| **Phone (home)** | **Phone (work)** | **ZIP code** |
| **Name of person filling out this form (if not patient)** |  | |
| **Name of referring or responsible party (if applicable)** | | |
| **PHARMACY INFORMATION:**  **Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **PRIMARY CARE CLINICIAN:**  **Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **INSURANCE INFORMATION:**  ***PLEASE PRESENT INSURANCE CARD FOR RECEPTIONIST TO COPY***  **PRIMARY**  **Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Secondary**  **Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **The above information is true to the best of my knowledge. I understand that I am financially responsible for all charges including added costs incurred due to any effort to collect for services rendered. I hereby also authorize the release of pertinent medical information required to process my claims.** | | |
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| **Signature of Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
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| **Demographics** | **Marital Status** | **Work/School** |
| Race\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Gender\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Religion\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sexual Orientation\_\_\_\_\_\_\_\_\_\_\_ | Single  Married  Separated  Divorced  Widow(er) | ­­­­­­­­Name of School or Workplace  ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current Position/Grade  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Highest Level Completed  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Please state the principal reason you are requesting a consultation or treatment.**

If necessary, use another sheet of paper.

**Please describe your mental health symptoms or concerns from the time of your first symptom to the present. When did they start? What have you experienced? How has it affected your functioning? What mental health providers and treatment modalities have your worked with before? What psychiatric medications and doses have you taken/been prescribed in the past and how did you respond to each them?**

If necessary, use another sheet of paper.

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| **Suicide** | |
| Check if you have ever thought about suicide. | ❑ |
| If “yes,” when was the last time? |  |
| Check if you have ever attempted suicide. | ❑ |
| If “yes,” when and how? |  |
| Check if you have thoughts about suicide now. | ❑ |
| **Injury to Others** | |
| Check if you have ever thought about hurting someone else. | ❑ |
| If “yes,” when was the last time? |  |
| Check if you have ever hurt someone else. | ❑ |
| If “yes,” when and how? |  |
| Check if you are thinking about hurting someone now. | ❑ |
| **Recent Stressful Life Events Check any of the following events that have occurred during the last 2 years.** | |
| Married | ❑ |
| Engaged | ❑ |
| Separated | ❑ |
| Divorced | ❑ |
| Serious argument | ❑ |
| Breakup of important relationship | ❑ |
| Child left home | ❑ |
| Death of spouse, other | ❑ |
| Bad health (behavior) of family member | ❑ |
| Difficulties with family member | ❑ |
| Personal injury, illness | ❑ |
| Sexual difficulties | ❑ |
| Difficulties, changes at school, work | ❑ |
| Retired, lost job | ❑ |
| Changed residence | ❑ |
| Legal difficulties, multiple traffic tickets | ❑ |
| Owe money | ❑ |

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| **Comments** |
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| **Alcohol Use** | |
| How many drinks do you consume in the average week? |  |
| Check if you ever felt that you were, or someone told you that you were, drinking too much? | ❑ |
| If “yes,” under what circumstances? | |
| **Drugs of Abuse** | |
| **Check if you have taken any of the following drugs.** | |
| None | ❑ |
| Marijuana | ❑ |
| Amphetamines/speed | ❑ |
| Heroin/opiates | ❑ |
| PCP | ❑ |
| LSD/hallucinogens | ❑ |
| Cocaine/crack | ❑ |
| Barbiturates/sedatives/downers | ❑ |
| If you checked one or more of the drugs, under what circumstances did you take it(them)? | |
| When did you most heavily use drugs? |  |
| When was the last time you took such drugs? |  |
| **Prenatal/Childhood History** | |
| **Check any items that apply to you and explain.** | |
| Mother’s pregnancy with you was abnormal | ❑ |
| Mother’s delivery of you was abnormal | ❑ |
| **Check if during childhood you—** | |
| Experienced changes in primary care giver(s) | ❑ |
| Experienced homelessness or were at risk for it | ❑ |
| Did not have food or basic necessities | ❑ |
| Had difficulty with reading, writing or arithmetic | ❑ |
| Had frequent suspensions from school | ❑ |
| Failed or repeated a grade | ❑ |
| Were awkward at games | ❑ |
| Had tics | ❑ |
| Were bullied | ❑ |
| Were exposed to community violence | ❑ |
| Mispronounced words, had a lisp, stutter/stammer | ❑ |
| Had nightmares, disturbed sleep, fear of the dark | ❑ |
| Ran away from home | ❑ |
| Were cruel to animals | ❑ |
| Often lied to families or others | ❑ |
| Set fires | ❑ |
| Moved often | ❑ |
| Were exposed to domestic violence | ❑ |
| Experienced abuse or neglect of any kind | ❑ |

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| **Comments** |
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| **Family History** | | | | **Major Illnesses** |
| **Name** | | **Age1** | **Occupation2** | List all major illnesses, including psychiatric, neurologic, alcoholism, drug abuse, suicide, and  suicide attempts. |
| **Mother** |  |  |  |  |
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| **Father** |  |  |  |  |
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| **Brothers** |  |  |  |  |
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| **Sisters** |  |  |  |  |
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| **Children** |  |  |  |  |
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| **Grandparents, uncles, and aunts (relationship)** | |  |  |  |
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*1Or if deceased, age at death. 2Or if deceased, cause of death.*

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| **Medical History** | |
| **Weight and Height** | |
| What is your current weight/height in pounds/inches? |  |
| Check if your weight has increased or decreased by 10 % or more in the past 6 months | ❑ |
| If checked, explain circumstances. | |
| **Sleep** | |
| **Check if you—** | |
| Have difficulty falling asleep | ❑ |
| Have difficulty waking up and falling back to sleep | ❑ |
| Are tired upon waking | ❑ |
| Have bad dreams, wet bed, sleepwalk, or other sleep disturbances | ❑ |
| **Tobacco Use** | |
| Check if you smoke. | ❑ |
| If checked, how much and for how long? |  |
| **Caffeine** | |
| Check if you use caffeine in any form. | ❑ |
| If checked, how much? |  |
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| **Current Medications, Supplements**  **and Drug Allergies** | |
| Please also include any frequently used over the counter medications | |
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| **Comments** |
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| **Medical History** | | |
| Age when first occurred | List all past and present medical problems as well as any surgery or accidents. | |
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| **Females–Menstrual History** | | |
| If you periods are irregular, please explain. | |  |
| Do you experience changes in your thoughts, feelings or behavior in the week before your periods. If so, please explain | |  |
| If you are taking a hormonal contraceptive (birth control pill, any IUD other than the copper one, implant, vaginal ring, depo shot), which one and have you noticed any impact on your thoughts, feelings or behaviors? | |  |