NEW PATIENT INTAKE FORM

GENERAL PERSONAL INFORMATION Today's Date:

NAME	DOB	AGE	GENDER
ADDRESS	CITY	STATE	ZIP

PHONE (CELL)	(WORK)	(HOME)
May I leave a message for you on cell? ☐ YES ☐ NO	At work? ☐ YES ☐ NO	At home? ☐ YES ☐ NO

Email Address:

Preference for appointment reminders (Choose One): ☐ TEXT ☐ EMAIL

Emergency Contact:	Relationship:	Phone:
Current therapist/psychiatric provider:		Phone:

Relationship Status: ☐ SINGLE ☐ MARRIED/PARTNERED ☐ DIVORCED ☐ SEPARATED ☐ OTHER:

Names of those that live with you and their relationship to you:

NAME	AGE	RELATIONSHIP YO YOU

OCCUPATION	EMPLOYER

REASONS FOR THIS VISIT

Describe the problem or concerns you would like help with:

Describe any recent changes that may contribute to this issue:

Why do you think you have this issue?

When did you first experience this issue?

Describe the outcomes you would like from our work together:

MENTAL HEALTH AND PSYCHIATRIC HISTORY

SYMPTOM SCREEN (check all behaviors and/or symptoms that you currently experience:

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/confusion
- ☐ Seasonal mood changes
- ☐ Sadness / depression
- ☐ Loss of pleasure / interest
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Self-harm behaviors
- ☐ Crying spells
- ☐ Lonliness
- ☐ Low self worth
- ☐ Guilt and/or shame
- ☐ Fatigue
- ☐ Problems focusing
- ☐ Change in appetite
- ☐ Lack of motivation
- ☐ Withdrawal from people
- ☐ Anxiety / worry
- ☐ Panic attacks
- ☐ Fear away from home
- ☐ Social discomfort
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Problems with pornography
- ☐ Frequent arguments
- ☐ Irritability / anger
- ☐ Thoughts of hurting others
- ☐ Flashbacks
- ☐ Hypervigilance
- ☐ Hearing voices others don't
- ☐ Seeing things others don't
- ☐ Suspicion/paranoia
- ☐ Racing thoughts
- ☐ Excessive energy
- ☐ Wide / frequent mood swings
- ☐ Sleep too much
- ☐ Can't sleep / trouble sleeping
- ☐ Nightmares
- ☐ Eating problems
- ☐ Gambling problems
- ☐ Computer addiction
- ☐ Aggressive behavior
- ☐ Problems with dugs and/or alcohol
- ☐ Sexual problems
- ☐ Relationship problems
- ☐ Work / school problems
- ☐ Other :
- ☐ Other :

Are your problems affecting any of the following?

- ☐ Handling everyday tasks
- ☐ Work / School
- ☐ Housing
- ☐ Recreational activities
- ☐ Self-esteem
- ☐ Sexual activity
- ☐ Legal problems
- ☐ Relationships
- ☐ Finances
- ☐ Hygiene
- ☐ Health
- ☐ Safety

Have you been diagnosed with a mental health or psychiatric problem in the past? ☐ YES ☐ NO

Diagnosis	Dates (or age) treated	By whom

Have you ever been hospitalized for psychiatric or mental health reasons? ☐ YES ☐ NO
If yes, when and why?

Have you ever attempted suicide? ☐ YES ☐ NO
If yes, when and how?

Have you ever engaged in self-harm behaviors? ☐ YES ☐ NO
If yes, when and how?

List medications and treatments previously tried (e.g. therapy, medications, other.)		
Treatment/medication/therapy	Length of use	Outcome / side effects

Family history of mental illness problems:			
	Relationship to you	Age of diagnosis	Treatment
☐ Depression			
☐ Anxiety			
☐ Schizophrenia			
☐ Bipolar (manic-depression)			
☐ Post-traumatic stress disorder			
☐ Alcohol / Substance Abuse			
☐ ADHD (ADD)			
☐ Suicide or attempted suicide			
☐ Other			

GENERAL MEDICAL AND HEALTH HISTORY

Primary Care Provider (PCP) Name:		
PCP Address:	PCP Phone:	PCP Fax:
On-going Medical Issues:		
Drug Allergies:		

List current medications (including over the counter, herbal supplements or herbal remedies)			
Name of medication	Dosage	Purpose	Prescriber

Comprehensive Review of Systems (Check any you are currently experiencing or have experienced in past 3 months):		
GENERAL	NECK	VASCULAR
☐ Weight loss or gain	☐ Lumps	☐ Pain in lower leg when walking
☐ Fatigue	☐ Swollen glands	☐ Leg cramping
☐ Fever or chills	☐ Pain	MUSCULOSKELETAL
☐ Weakness	☐ Stiffness	☐ Muscle or joint pain
☐ Trouble sleeping	BREASTS	☐ Stiffness
SKIN	☐ Lumps	☐ Back pain
☐ Rashes	☐ Pain	☐ Redness of joints
☐ Lumps	☐ Discharge	☐ Swelling of joints
☐ Itching	☐ Breast Feeding	☐ Trauma
☐ Dryness	RESPIRATORY	NEUROLOGIC
☐ Color changes	☐ Cough	☐ Dizziness
☐ Hair and nail changes	☐ Sputum	☐ Fainting
HEAD	☐ Coughing up blood	☐ Seizures
☐ Headaches	☐ Shortness of breath	☐ Weakness
☐ Head injury	☐ Wheezing	☐ Numbness
☐ Neck pain	☐ Painful breathing	☐ Tingling
EARS	CARDIOVASCULAR	☐ Tremor
☐ Decreased hearing	☐ Chest pain or discomfort	☐ Memory Loss
☐ Ringing in ears	☐ Tightness	☐ Incoordination
☐ Earache	☐ Palpitations	☐ Restless legs, especially at night
☐ Drainage	☐ Shortness of breath with activity	☐ Internal restlessness, with medication
EYES	☐ Shortness of breath lying down	☐ Involuntary lips, tongue, mouth movements
☐ Vision loss or change	☐ Swelling in extremities	☐ Other involuntary movements
☐ Glasses or contacts	☐ Suddenly waking up short of breath	Where?
☐ Pain	GASTROINTESTINAL	☐ Hyper reflexes
☐ Dryness	☐ Swallowing difficulties	HEMATOLOGIC
☐ Redness	☐ Heartburn	☐ Bruise easily
☐ Blurry/double vision	☐ Change in appetite	☐ Bleed easily
☐ Flashing lights	☐ Nausea	ENDOCRINE
☐ Specks	☐ Change in bowel habits	☐ Heat or cold intolerance
☐ Glaucoma	☐ Rectal bleeding	☐ Hot flashes
☐ Cataracts	☐ Constipation	☐ Frequent urination
NOSE	☐ Diarrhea	☐ Excessive thirst
☐ Stuffiness	☐ Yellow eyes or skin	☐ Change in appetite
☐ Discharge	☐ Abdominal Pain	☐ Weight loss
☐ Itchiness	URINARY	☐ Night sweats
☐ Hay fever	☐ Frequency	☐ Excessive sweating
☐ Nosebleeds	☐ Urgency	OTHER
☐ Sinus pain	☐ Burning or pain on urination	☐
MOUTH/THROAT	☐ Blood in urine	☐
☐ Bleeding	☐ Incontinence	☐
☐ Dentures	☐ Change in urinary strength	☐
☐ Sore throat	☐ Frequently waking to urinate.	
☐ Dry mouth	How often?	
☐ Sore tongue		
☐ Hoarse voice		
☐ Thrush		
☐ Sores that won't heal		

Personal and Family History of Health Problems. Check (list) all past and present for you and your family.				
	You, Current	You, Past — When?	Family History	Relationship to you
Anemia				
Asthma				
Cancer				
Chronic Pain				
Diabetes				
Head Injury				
Heart Disease				
High Blood Pressure				
High Cholesterol				
HIV +				
Kidney Disease				
Liver Disease (including hepatitis)				
Seizures/Epilepsy				
Stomach/ GI Problems				
Thyroid Disease				
Other, specify:				
Other, specify:				

PERSONAL LIFESTYLE

Do you exercise regularly? ☐ YES ☐ NO	How often per week?
What type of exercise?	Why do you exercise?

Worried about your eating habits? ☐ YES ☐ NO	Ever binged, purged, severely restricted calories to manage your weight? ☐ YES ☐ NO
Describe:	

What are your stress management strategies?
Where do you get emotional or spiritual support?

SUBSTANCE USE HISTORY (PAST AND PRESENT)

	First use?	How much?	How often?	Last Use?	Ever a problem?	Consequences: tolerance, withdrawal, legal, job or relationship problems?
Caffeine						
Tobacco						
Alcohol						
Marijuana						
Pain pills						
Other/illicit drugs						
Prescribed drugs						

ADDICTION AND RECOVERY

Ever experienced the following addictions (past or present)?
☐ Alcohol ☐ Drugs ☐ Gambling ☐ Pornography ☐ Sex or Love ☐ Food ☐ Codependency ☐ Other:

Briefly describe your addiction history:	
Are you currently in recovery? ☐ YES ☐ NO	How long?
Member of a 12 Step Program? ☐ YES ☐ NO	Other Recovery Program? ☐ YES ☐ NO
Describe the nature of your recovery?	

SOCIAL / FAMILY HISTORY

Ethnic, cultural and/or religious background:	
Where were you born and raised?	Who raised you?
List siblings and ages:	Parents deceased? ☐ YES ☐ NO If no, list names and ages: (Including step-parents)
Current relationships with siblings:	Current relationships with parents:

Check any environmental factors present during your childhood and adolescence:

☐ Parental divorce / separation	☐ Death in family	☐ Parental Illness
☐ Moving frequently	☐ Parental unemployment	☐ Financial stress
☐ Family member disability	☐ Crime victim	☐ Emotional abuse
☐ Physical Abuse	☐ Sexual abuse	☐ Violence in home
☐ Substance abuse (self or parent)	☐ Verbal abuse	☐ Other:

Military Experience? ☐ YES ☐ NO	Branch?	Service dates?
How was your experience in the military?		

List any legal history (arrests, convictions, lawsuits, DHS involvement, custody:
☐ NONE

Completed high school? ☐ YES ☐ NO ☐ GED	College? Degree and area of study?
How did you do in school?	

_____ _____

Patient Signature Date