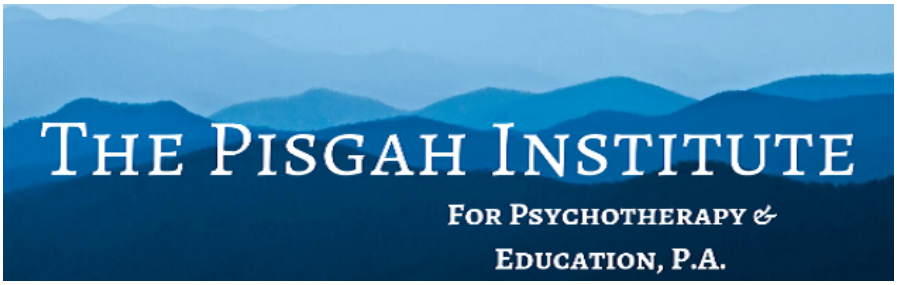

FOR OFFICE USE ONLY

Appointment Date & Time _____

Intake Date _____ Approved ☐ YES ☐ NO

Referred by _____

Patient _____ Date of Birth _____

Phone _____

Address _____

Email _____

Insurance _____ Policy # _____

Group # _____ Subscriber _____

Date of Birth _____ Insurance Phone _____

Copay _____ Co-Insurance _____

Self Pay _____ Agrees to fees _____

What are the problem(s) for which you are seeking help?

1. _____

2. _____

3. _____

List ALL current prescription medications and how often you take them (if none, write "none").
Medication Name / Total Daily Dosage / Estimated Start Date

_____

_____

_____

List ALL known medication allergies:

_____

_____

_____

List name and phone number of primary care physician:

Name: _____ Phone: _____

Have you ever experienced any of the following?

Extreme depressed mood?	☐Yes ☐No	Unexplained losses of time	☐Yes ☐No
Dramatic mood swings	☐Yes ☐No	Unexplained memory lapses	☐Yes ☐No
Rapid speech	☐Yes ☐No	Alcohol/substance abuse	☐Yes ☐No
Extreme Anxiety	☐Yes ☐No	Frequent body complaints	☐Yes ☐No
Panic attacks	☐Yes ☐No	Eating disorder	
Phobias	☐Yes ☐No	☐Yes ☐No	
Sleep disturbances	☐Yes ☐No	Body Image problems	☐Yes ☐No
Hallucinations	☐Yes ☐No	Repetitive thoughts (e.g. obsessions)	☐Yes ☐No

Please explain:

_____

_____

_____

Check if you have ever tried the following:
***If yes, how long and when did you last use?**

Methamphetamine	☐Yes ☐No	Pain Killers	☐Yes ☐No
Cocaine	☐Yes ☐No	Methadone	☐Yes ☐No
Stimulants (pills)	☐Yes ☐No	Tranquilizer/Sleeping Pills	☐Yes ☐No
Heroin	☐Yes ☐No	Ecstasy	☐Yes ☐No
LSD or Hallucinogens	☐Yes ☐No	Alcohol	☐Yes ☐No
Marijuana	☐Yes ☐No		

Please explain:

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.) ***Please circle and list family member.***

Alcohol/Substance Abuse	☐Yes ☐No	Eating Disorders	☐Yes ☐No
Anxiety	☐Yes ☐No	Obsessive Compulsive Behavior	☐Yes ☐No
Depression	☐Yes ☐No	Schizophrenia	☐Yes ☐No
Domestic Violence	☐Yes ☐No	Suicide Attempts	☐Yes ☐No

.