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Individual Intake Form

The rules and limits of confidentiality apply to the information included in this form

Name: _____ Social Security #: _____

Date of Birth _____ Age _____

Address _____

_____

Phone Numbers: May I contact you at the following:
Home ( ) yes/no
Cell ( ) yes/no
Work ( ) yes/no
Email: _____ yes/no

Marital Status: _____

Living with spouse/partner? _____ Number of years together _____

Employer/School _____ Occupation _____

How long on present job? _____

Last school grade completed? _____

Primary Care Physician _____ Phone # _____

Emergency Contact _____ Phone # _____

Insurance Information
Health Plan/Insurance _____ Policy # _____

Phone # _____

Subscriber Name _____ Subscriber SS #_____
Mental Health Insurance (if different than above): _____

Major reasons for seeking help at this time: _____

_____

_____

_____

How long have you had these problems or symptoms?: _____

How often do they occur? _____

What have you tried already? _____

Past or current psychiatric treatment: (type; provided by; year; helpful?)

Please describe any significant incidents, traumas, developmental concerns, learning issues that would be helpful for me to know about you: _____

Do you have any serious or chronic medical conditions (including past surgeries)? _____

Have you had any serious medical accidents or injuries, head injury or seizure history? Yes / No
If yes, please explain: _____

Are you taking any medications? Yes / No
If yes, please list: _____

Do you use alcohol? Yes / No
How much per day/week _____
Age when started drinking? _____
Last drink taken (time and amount): _____

Do you use drugs? Yes / No
What kind(s): _____

Amount/frequency: _____
Age started using: _____
Last use (time and amount): _____

Does anyone in the family feel a member has a problem with:
Alcohol: Yes / No
Drugs: Yes / No
If so, explain: _____

_____

Previous treatment programs (dates, locations, if possible): _____

_____

Has family member's drinking/drug use caused problems in the family or with relationships? _____

_____

Has family member's drinking/drug use caused job problems? _____

_____

Is it difficult for family member to stop or control the amount used? Yes / No

Have you or a family member ever been arrested for a D.U.I (driving under the influence) or other drug related offense(s)? Yes / No

Do you use tobacco products? Yes / No
Amount/frequency: _____
Age when use started: _____ When did use stop? _____

How many cups of caffeinated beverages do you drink per day (coffee, tea, soda, energy drinks, etc):_____

_____

Have any family members had any financial problems, legal difficulties/problems or previous incarceration? Yes / No
If yes, dates and details: _____

_____

Have relatives/significant others had psychiatric symptoms or drug or alcohol problems?_____

_____

_____

Have any family members had problems with criminal offenses or been incarcerated? _____

_____

Others living in the home? (names, ages, relation)

Goals for Therapy:

Additional Information: