

Confidential Intake Information

Personal Information

Last Name _____ First Name _____

Gender M F Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Other Phone _____

Is it acceptable to call and leave a message at your home phone? Y/N

Is it acceptable to call and leave a message at your other phone? Y/N

Email Address _____

Is it acceptable to contact you by email? Y/N

If you have answered no to all three, how can I best leave you a message?

Health Information

Primary Care Physician _____ Phone _____

Clinic Location _____

Do you/the patient currently take any medications? Y/N

If yes, please describe:

Are you interested in being referred to a psychiatrist or psychiatric nurse practitioner if it is discovered as something that could be beneficial to your/the patient's treatment? Y/N

Have you/the patient ever taken psychiatric medication in the past? Y/N

If so please list:

Please list below any medical conditions for which you have recently or are currently being treated.

Have you/the patient in the past ever attempted/thought about suicide? Y/N

If yes, please describe:

Have you/your child ever been in an alcohol or drug treatment program? Y/N

Please describe when and where this was, and for what reason?

Emergency

In case of emergency please contact the following individual

Name _____ Phone _____

Cell Phone _____ Relationship to you _____

Please bring this form into the first session