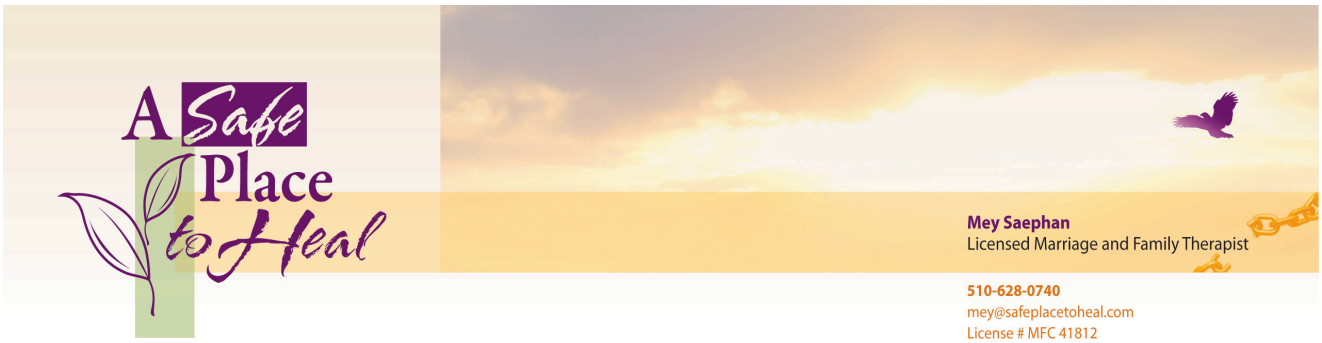

New Patient Intake Form

Name_____ Age, _____DOB_____ Today's date_____

Significant other_____Age, _____DOB_____

Children's Names _____age_____M F
_____age_____M F
_____age_____M F

Address_____City_____zip_____

Phone # H _____ W_____ Cell_____
Is it OK to leave a message?_____ On which number? H W or Cell?
Email:_____ Is it okay to send workshop or therapy related info?_____

Who should I contact in an emergency? _____Relationship_____

Address_____ phone_____

Occupation_____Employer_____Using insurance Y or N ?

Name of Insurance_____Subscriber/insured _____

Subscriber DOB _____Subscriber ID#_____

Group#_____

Relational status: check all that apply & appropriate dates):
____Single _____Live with significant other _____Engaged _____Date of Wedding
____Married _____Divorced_____Remarried _____Other please explain _____

_____

Past/Present medical care: (major medical problems, surgeries, accidents, falls, illness, injuries):_____

_____

Past/Present Drug/alcohol use: (Include drug treatment/s & support groups like AA, NA, Celebrate Recovery): _____

_____

Suicide attempt/s or violent behavior (describe: past present, ages, reasons, circumstances, how, etc)

_____

_____

_____

Family Medical (Describe any illness that runs in the family: cancer, depression, epilepsy, suicide etc):

_____

_____

Did you have an in-utero or birth trauma?_____ If yes, what happened?_____

_____

What are your reasons for coming to counseling now?_____

_____

___abortion	___in-law difficulties	___anger
___alcohol/drug problems	___marriage problems	___suicidal thoughts
___Attachment issues	___occupational problems	___eating disturbances
___behavior problems	___personality growth	___prior trauma
___communication	___self image	___faith
___children/parenting	___sexual difficulties	___unwanted pregnancy
___depression/anxiety	___social activities	___grief/loss
___school difficulties	___stress	___sexual abuse
___hurts and conflicts	___infertility	other_____

If needed would you be willing to sign a Release of Information so that we might obtain information from your previous therapist or medical doctor? _____

How did you hear about me? _____friend ___Yelp, _____Theravive, _____Therapy Network, _____Christian Therapist Directory _____Google search phrase_____

May I call or send a thank you card to this person?_____, if so what is their contact info?
Name_____Phone_____
Address_____

Are you presently taking medication (s)? If so what, how often and how much?_____

_____

_____

Name of prescribing physician _____phone _____

Do you have current medical problems that may be affecting your mental health?_____

_____

Do you belong to a church, synagogue,_____ etc.?_Y N Where _____

Are you looking to integrate your religious beliefs/spirituality in your therapy work? If yes, in what way?

_____

Doc 1.13.15