SPECIALTY BEHAVIORAL HEALTH - INTAKE FORM

This information you provide will be used to plan your treatment and is held strictly confidential. You may leave any item blank if you don't feel comfortable providing an answer. After completing this form, please give it directly to your doctor or therapist at your first visit. Thank you in advance for your efforts.

Name: _____ Social Security # : _____
Last, First, Middle

Birth Date: _____ / _____ / _____ Age: _____ Gender: _____

Marital Status: ☐ Never Married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address: _____ _____
Number and Street City

_____ _____ May we send mail there? ☐ Yes ☐ No
State Zip Code

Home Phone: (_____) - _____-_____ May we leave a message? ☐ Yes ☐ No

Work Phone: (_____) - _____-_____ May we leave a message? ☐ Yes ☐ No

Mobile Phone: (_____) - _____-_____ May we leave a message? ☐ Yes ☐ No

E-mail: _____ May we email you? ☐ Yes ☐ No
Please be aware that email may not be confidential.

Emergency Contact Information:

_____ _____ (_____) - _____-_____
Name Relationship Phone Number

REFERRED BY: ☐ Self ☐ Friend ☐ Family Member ☐ Medical Doctor _____

☐ Psychiatrist _____ ☐ Other _____

OCCUPATION: ☐ Student: _____ ☐ Employed: _____

☐ Unemployed ☐ Retired: _____ ☐ Other: _____

CULTURAL BACKGROUND:

Place of Birth: _____ Race/Ethnicity:_____

Religion: _____ How often do you attend services? _____

Do you or your family speak a language other than English? ☐ No ☐ Yes _____

Sexual Orientation : ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Unsure ☐ Other _____

FAMILY BACKGROUND:

Please list the members of your current family, including ages, occupations, and any comments about them or comments about your relationship with them:

Name	Relationship	Age	Occupation	Comment(s)
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____

Please list members of extended family that are key figures in your life (examples: siblings, parents, grandparents, etc):

Name	Relationship	Age	Occupation	Comment(s)
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____

Please check and explain any past, present, or impending family issues:

☐ Deaths _____ ☐ Divorce _____

☐ Financial Crisis _____ ☐ Injuries/Illness _____

☐ Abuse _____ ☐ Other _____

Has anyone in your family ever had:

Psychiatric problems (depression, anxiety, psychosis, etc)? ☐ Yes ☐ No ☐ Unsure

Unhealthy alcohol or drug use? ☐ Yes ☐ No ☐ Unsure

An attempted or completed suicide? ☐ Yes ☐ No ☐ Unsure

LEGAL BACKGROUND:

Do you have any current, pending, or future legal issues? ☐ Yes ☐ No ☐ Unsure

If 'Yes' or 'Unsure,' please explain: _____

_____

MEDICAL AND HEALTH BACKGROUND:

Do you have any current medical problems? ☐ Yes ☐ No If 'Yes,' please describe below:

_____

_____

Are you currently taking any medications? ☐ Yes ☐ No If 'Yes,' please list below:

_____

_____

Have you been hospitalized or treated for serious medical problems in the past? ☐ Yes ☐ No

Who is your regular health care provider? _____
(Note: We will not contact this person without your authorization, except in case of emergency)

Are you having any trouble with your sleep? ☐ Yes ☐ No If 'Yes,' explain below.

☐ Difficulty falling asleep ☐ Sleeping too much ☐ Waking up during night

☐ Disturbing dreams ☐ Sleeping too little ☐ Not feeling refreshed

Are you having any difficulties with your appetite or eating habits? ☐ Yes ☐ No If 'Yes,' explain below.

☐ Eating less ☐ Eating more ☐ Restricting ☐ Binging or out-of-control eating ☐ Diminished appetite

Do you currently drink alcohol? ☐ Yes ☐ No Have you drank alcohol in the past? ☐ Yes ☐ No

Do you currently use any drugs? ☐ Yes ☐ No Have you tried or used drugs in the past? ☐ Yes ☐ No

How many times per week do you exercise? _____ How long each time? _____

What type(s) of exercise? _____

How do you relax yourself? _____

RELATIONSHIPS:

Are you currently involved in an intimate relationship? ☐ Yes ☐ No ☐ Unsure

If 'Yes' or 'Unsure:' Name:_____ How Long: _____

Who do you hang-out with most often? _____

Who do you talk with about serious things in your life? _____

Who is aware of the problem(s) you are having? _____

Who is critical of you? _____

STRENGTHS AND LIKES:

Which areas of your life are going well? _____

Favorite hobbies or activities: _____

Favorite movies, books, or TV shows: _____

PSYCHOLOGICAL BACKGROUND:

Are you currently seeing another psychologist, psychiatrist, or therapist?	☐ Yes	☐ No	
Have you ever seen a psychologist, psychiatrist, or therapist in the past for any reason?	☐ Yes	☐ No	
Are you currently having thoughts about ending your life or wanting to die?	☐ Yes	☐ No	
Have you had thoughts about ending your life or wanting to die in the past 3 months?	☐ Yes	☐ No	
Have you ever attempted to kill or harm yourself in the past?	☐ Yes	☐ No	
Are you currently having thoughts about wanting to hurt or harm somebody else?	☐ Yes	☐ No	
Have you ever been involved in a physical fight or hurt somebody in the past?	☐ Yes	☐ No	
Have you ever been a victim of rape or received unwanted sexual contact?	☐ Yes	☐ No	☐ Unsure
Have you ever been exposed to physical abuse, emotional abuse, or other trauma?	☐ Yes	☐ No	☐ Unsure
Have you ever witnessed a horrific or terrifying experience (e.g. death)?	☐ Yes	☐ No	☐ Unsure

PROBLEM DESCRIPTION:

Briefly describe the problem(s) for which you are seeking help:

_____

_____

_____

How long have you been dealing with the problem(s)? _____

How has your relationships, work, or sense of well-being been affected by the problem(s)? _____

_____

How have you tried to fix or cope with the problem(s)? _____

_____

What are your treatment goals for the problem(s)? _____

_____