

PATIENT INTAKE FORM

Client Name: _____ Date: _____

Veteran: Yes _____ No _____ Date of Birth: _____

Age: _____ Height: _____ Weight: _____ Racial Background: _____

Homeless (Circle Y or N): Present - Yes/ No Past: Yes/ No Who do you reside with? _____

Relationship Status: _____ Highest Level of Education: _____

Special Education or IEP? If yes, what year? _____ Currently Employed: Yes/ No

Work History in the last 5 years (Dates and Names of Employer):

Legal History (arrests and convictions with dates and location):

List any physical symptoms, concerns, and diagnoses: _____

List any mental health diagnoses: _____

List mental health providers including dates seen: _____

Current medications: _____

List any substance abuse treatment or inpatient psychiatric hospitalizations including dates:

| Substance Use | Past Use | Current Use | Amount/ Frequency |
|----------------------------|----------|-------------|-------------------|
| Cigarettes | | | |
| Alcohol | | | |
| Marijuana | | | |
| Cocaine or crack | | | |
| Methamphetamine | | | |
| Pills not prescribed to me | | | |
| Other Drugs/ Substances | | | |

Please indicate whether or not you have in the past or currently experience the following symptoms:

| | Past | Current | | Past | Current |
|---|------|---------|---|------|---------|
| Difficulty falling or staying asleep | | | Startle Easily | | |
| Sleeping too much | | | Memories of past upsetting event(s) | | |
| Change in appetite, unintentional weight loss or gain | | | Difficulty controlling temper | | |
| Use of laxatives or exercise excessively | | | Thoughts or plan to harm or kill others | | |
| Periods of sadness lasting more than 2 weeks | | | Excessive, uncontrollable worry | | |
| Frequent crying/tearfulness | | | Little/ no interest in sex | | |
| Panic Attacks | | | Withdrawing from others | | |
| Anxiety | | | Increased irritability | | |
| Thoughts of self harm or suicide | | | Elevated mood/ excessive energy lasting at least 1 week | | |
| Attempts of self harm or suicide | | | Engaging in risky behaviors | | |
| Difficulty with concentration or attention | | | Hearing/seeing/ tasting/ smelling things others do not | | |
| Issues with memory | | | Odd beliefs, desires, or behaviors | | |

Other Concerns:

Are you able to complete the following daily activities (Circle Y/N):

Driving ... Y/N

Prepare & cook meals using microwave/ stove ...Y/N

Dress Yourself ...Y/N

Shower/ Bathe, Brush Teeth ...Y/N

Household chores (vacuuming, mopping, organizing, feeding pets) ...Y/N

Manage your finances (checking/savings accounts, pay bills, make change)... Y/N