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Patient Intake Form

Today's date _____

Personal Information

Patient's name _____ Date of birth _____

Address _____

Street

Apt #

City

State

Zip code

Primary phone _____ Email _____

Employer or school name _____

Highest level of education completed or current grade/major/field _____

Emergency contact name _____ Relationship _____

Emergency contact phone _____

Referral's name _____ Relationship _____

Is the patient currently covered by Medicaid or Medicare? _____

Family Information

Marital status (circle):

Single

Cohabiting

Married

Separated

Divorced

Widowed

Dates of marriage, divorce, death of spouse, etc. _____

People currently living in household (names/ages/relationships) _____

Current partner name (if relevant) _____ Age _____

Last updated: 01/01/2020

History of relevant family events/stressors (e.g., adoptions, divorces, deaths, substance abuse):

Biological family history of psychological issues (e.g., ADHD in sibling, bipolar disorder in uncle):

Medical Information

Physician's name _____ Phone _____

Reason for most recent visit _____ Date of visit _____

Current medical condition(s) _____

Current medications (name, dose, frequency) _____

Lifestyle Information

Current alcohol or drug use (type/frequency/duration at such frequency) _____

Previous alcohol or drug use (type/frequency/duration at such frequency) _____

Primary Concerns

Briefly describe the problems or concerns that bring you here today:

Previous Services

List previous therapies, treatment, evaluations, hospitalizations, tutoring, academic accommodations, etc. (including any substance use treatment).

Therapist's name/agency/hospital

Dates or ages when received

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Your signature below indicates that you consent to treatment (see more details in Patient Services Agreement).

Patient's printed name _____

Patient's signature _____ Date _____