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## **Patient Intake Form**

Today's date \_\_\_\_\_

### **Personal Information**

Patient's name \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_

Street

Apt #

City

State

Zip code

Grade \_\_\_\_\_ School name \_\_\_\_\_

Parent primary phone \_\_\_\_\_ Parent email \_\_\_\_\_

Emergency contact name \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency contact phone \_\_\_\_\_

Referral's name \_\_\_\_\_ Relationship \_\_\_\_\_

Is the patient currently covered by Medicaid or Medicare? \_\_\_\_\_

## Parent Information

Mother's name \_\_\_\_\_ Phone \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_

Street

Apt #

City

State

Zip code

Father's name \_\_\_\_\_ Phone \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_

Street

Apt #

City

State

Zip code

Parents' marital status (circle):

Married

Separated

Divorced

Widowed

Never  
married

Other

*If parents are divorced, and only one parent providing written consent to treatment, a copy of custody arrangements specific to authorization for medical/psychological treatment from divorce decree is required prior to beginning treatment.*

## Medical Information

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

Current medical condition(s) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current medications (name, dose, frequency) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **Family Information**

People currently living in household (names/ages/relationships) \_\_\_\_\_

\_\_\_\_\_

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):

\_\_\_\_\_

\_\_\_\_\_

## **Primary Concerns**

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Previous Services

List previous therapies, treatment, evaluations, hospitalizations, tutoring, accommodations, etc.

Therapist's name/agency/hospital

Dates or ages when received

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

Patient's printed name \_\_\_\_\_

Parent/guardian's name \_\_\_\_\_ Relationship \_\_\_\_\_

Parent/guardian's signature \_\_\_\_\_ Date \_\_\_\_\_