# Patient Information

**Individual Intake Form**

Date:

Name Insurance Carrier? Yes No Date of Birth Age

Address

Street City, State Zip Code

Phone ( ) - Email Emergency Contact Phone ( ) -

Referral Source Marital Status

Employer Occupation

# Responsible Party (if different from above)

Name Insurance Carrier? Yes No Date of Birth Age

Address

Street City, State Zip Code

Phone ( ) - Email Emergency Contact Phone ( ) -

Employer Occupation

# Insurance Information

Insurance Co

Member ID Group # Insured relationship to patient

Relationship Status Single Married Divorced Widow

Partner name and brief description

# Children

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Age | Natural/ Step/ Half | Describe relationship (favors one parent, open to both) |
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Have you ever…

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Yes/No | # times | When | Did you receive counseling/ was it effective? |
| Miscarried |  |  |  |  |
| Abortion |  |  |  |  |
| Put up foradoption |  |  |  |  |

Parents/ Sibling

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Age | Relation | Bio/Half | Brief description of relationship |
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| --- | --- | --- |
| MedicalPrimary Doctor  | Phone |   |
| Specialist Medications | Phone |   |
| Name | Dosage |  | Reason | Relief/ Issues from med |
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| Are you currently or have you attended therapy? If so, please describe (benefits, reason forseeking another professional). |
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| Describe your current living situation (living together/ apart, children, caring for parents). |
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| Do you have religious and/or spiritual beliefs? Please describe. |
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| Is there anything you feel I should know about you? If so, please feel free to describe. |
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| Please circle the following symptoms you experience then rank your top 3 in order of importance to you. |
| Depression | Sexual Concerns | Sexual Orientation Concerns |
| Academic Concerns | Excessive Fears | Culture Related Issues |
| Low Self-esteem | Paranoia | Hallucinations |
| Anxiety | Anger | Career Concerns |
| Stress | Violent Behavior | Alcohol/ Drugs |
| Panic Attacks | Parenting difficulty | Eating Issues |
| Suicidal Thoughts/ Behaviors | Grief | Sleeping Difficulty |
| Relationship Issues | Dependency | Social Concerns |
| Major Changes in Your Life | Thoughts harm to others | Obsessive Thoughts |
| Physical Abuse | Sexual Assault/ Rape | Compulsive Behaviors |
| Psychological Abuse | Child Sexual Abuse | Other: |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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