INTAKE REGISTRATION

Client's Name: _____ **Today's Date:** _____

Hm. address: _____ **City/St** _____ **Zip** _____

May we mail to above address? Y N Mailing addr : _____

Home Phone: (_____) _____ **Work Phone:** (_____) _____

Cell Phone: (_____) _____

May we leave messages for you at home [Y N], work [Y N], cell [Y N]?

Birthdate: _____ **Age:** _____ **Gender**: _____ **Soc. Sec. #:** _____

Marital Status: _____**Single** _____**Married** _____**Separated** _____**Divorced** _____**Other**_____

Others living in the home (include names, birthdates & relationship to client)**:** _____

_____

Referred by: _____

Primary Physician: _____ **Phone:** (_____) _____

Address: _____ **City/St** _____ **Zip** _____

Emergency contact Person _____ **Phone:** (_____) _____

Primary Insurance Co.: _____ **Ins. Co. Phone:** (_____) _____

Insurance Co. Address: _____ **City/St** _____ **Zip** _____

I.D. #: _____ **Group #:** _____ **Co-Pay Amt.:** _____

Policyholder's Name & Addr: _____

Policyholder's Birthdate: _____ **Soc. Sec. #:** _____ **Phone #:** (_____) _____

Policyholder's Employer: _____

Secondary Insurance Co.: _____ **Ins. Co. Phone:** (_____) _____

Insurance Co. Address: _____ **City/St** _____ **Zip** _____

I.D. #: _____ **Group #:** _____ **Co-Pay Amt.:** _____

Policyholder's Name & Addr: _____

Policyholder's Birthdate: _____ **Soc. Sec. #:** _____ **Phone #:** (_____) _____

Policyholder's Employer: _____

For Office Use Only **D:** _____ **CPT:** _____ **EMP:** _____ **THPST:** _____

CLIENT NAME: _____ **Soc. Sec. #:** _____

HEALTH CARE INFORMATION:

When did you last see a physician? _____ **Why?** _____

What is the date of your last physical examination? _____

Current health problems: _____

Hospitalizations or major medical problems: _____

_____

Allergies: _____

Adverse reactions to medication(s)? _____

_____

CURRENT MEDICATIONS:

Medication	Dosage	Frequency	Date Began	Reason

PREVIOUS MEDICATIONS FOR MENTAL HEALTH DISORDERS:

Medication	Dosage	Frequency	Date Began	Reason

PREVIOUS COUNSELING / ADDICTION TREATMENT:

Reason	Counselor	Dates	Outcome
1.			
2.			
3.			

SUBSTANCE USE HISTORY:

Do you use/have you used tobacco? ___**Never** ___**Past** ___**Currently. Frequency of use:**___ **per/day wk mo yr**

Do you use/have you used alcohol? ___**Never** ___**Past** ___**Currently. Frequency of use:**___ **per/day wk mo yr**

How much caffeine do you use, including cola drinks? _____**per/day wk mo yr**

Do you use/have you used recreational drugs? ___**Never** ___**Past** ___**Currently**

Drug(s) of choice: _____ **Frequency of use:**___ **per/day wk mo yr**

EDUCATION:

Patient's Education: ___**Elementary** ___**H.S.** ___**G.E.D.** ___**Trade Sch.** ___**College** ___**Grad. Sch.**

EMPLOYMENT:

Your job title: _____ **Employer's Name:** _____

Partner's job title: _____ **Employer's Name:** _____

CLIENT NAME:_____ **DATE:**_____

Describe the problem that brought you here today:

_____

_____

_____

_____

_____

_____

What prompted you to come in now?_____

Check those items below that describe your experience in the past month.
Circle those items below that describe your experience in the past one to five years:

Dt. Began		Dt. Began		Dt. Began	
_____	☐ Sadness	_____	☐ Problematic Internet Use	_____	☐ Often relive traumatic memories
_____	☐ Poor appetite	_____	☐ Increased activity	_____	☐ Compulsive behaviors
_____	☐ Increased appetite	_____	☐ Shortness of breath	_____	☐ Fear Intimacy
_____	☐ Lack of enjoyment of usual activities	_____	☐ Wake up too early	_____	☐ Fear leaving house
		_____	☐ Dizzy/faint	_____	☐ Fear closed in places
_____	☐ Trouble performing job	_____	☐ Startle easily	_____	☐ Experience trembling/shaking
_____	☐ Poor concentration	_____	☐ Feel fatigued	_____	☐ Memory problems
_____	☐ Perfectionism	_____	☐ Go on buying sprees	_____	☐ Lack motivation
_____	☐ Frequent worry	_____	☐ Feel empty	_____	☐ Feel shy often
_____	☐ Anger problems	_____	☐ Excessive perspiration	_____	☐ Procrastinate often
_____	☐ Tearfulness/ Crying spells	_____	☐ Fear I'm dying	_____	☐ Unable to relax
_____	☐ Feel hopeless	_____	☐ Feel restless	_____	☐ Experience bizarre unwanted thoughts
_____	☐ Excessive sleep	_____	☐ Have distressful memories	_____	☐ Fears or Phobias
_____	☐ Weight changes	_____	☐ Feel detached	_____	☐ Problematic gambling
_____	☐ Change in sexual function	_____	☐ Avoid certain thoughts/feelings	_____	☐ Experience flushes and chills
_____	☐ Thoughts of harming self			_____	☐ Frequent jealous feelings
_____	☐ Thoughts of harming others	_____	☐ Frequent nightmares	_____	☐ Stay up for days with sleeping
_____	☐ Feeling nervous	_____	☐ Avoid social situations	_____	☐ Experienced physical abuse
_____	☐ Panic suddenly	_____	☐ Low self-esteem	_____	☐ Lose periods of time
_____	☐ Feel excessive guilt	_____	☐ Bulimia		
_____	☐ Easily irritated	_____	☐ Easily hurt by criticism		
_____	☐ Lack energy	_____	☐ Recent loss(es)		
_____	☐ Racing thoughts	_____	☐ Marital problems		
_____	☐ Indecisiveness	_____	☐ Difficulty trusting others		
_____	☐ Sleep difficulties	_____	☐ Experienced emotional abuse		
_____	☐ Hear voices	_____	☐ Numbness/tingling		
_____	☐ Experienced sexual abuse	_____	☐ Recurring dreams		

What have you tried to remedy the situation? _____

_____