**PRE-INTAKE FILLABLE FORM**

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| **Name**  | **Date** |
| **Street**  | **Suite/Apt. #**  |
| **City**  | **State**  | **ZIP code**  |
| **Phone (primary)** **Is it ok to leave messages at this number?** **[ ]**  | **Phone (work)** **Is it ok to leave messages at this number?** **[ ]**  |
| **Name of person with whom you live**  | **Relationship**  |
| **Email Address**  |
| **Age**  | **Date of birth (month/day/year)**  |
| **Emergency Contact Name**  | **Relationship**  |
| **Street**  | **Suite/Apt. #**  |
| **City**  | **State**  | **ZIP code**  |
| **Phone (primary)**  | **Phone (work)**  |
| **Name/Relationship of person filling out this form (if not patient)**  |
| **Name of referring or responsible party (if applicable)**  |
| **PHARMACY INFORMATION:****Name** **Location** **Phone**  |
| **PRIMARY CARE CLINICIAN:****Name** **Location** **Phone**  |
| **INSURANCE INFORMATION:****Insured’s Name** **Date of Birth** **Relationship to patient** **Address** **City****State** **Zip Code** **Employer** |

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| **Demographics** | **Marital Status** | **Work/School** |
| Race\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gender\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Religion\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sexual Orientation\_\_\_\_\_\_\_\_\_\_\_Age and DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | SingleMarriedSeparatedDivorcedWidow(er) | ­­­­­­­­Name of School or Workplace­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Current Position/Grade\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Highest Level Completed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Please state the principal reason you are requesting a consultation or treatment.**

**Please describe your mental health symptoms or concerns from the time of your first symptom to the present. When did they start? What have you experienced? How has it affected your functioning?**

**What mental health providers and treatment modalities have your worked with before?**

**What psychiatric medications and doses have you taken/been prescribed in the past and how did you respond to each them?**

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| **Suicide** |
| Check if you have ever thought about suicide. [ ]  |  |
|  If “yes,” when was the last time? |       |
| Check if you have ever attempted suicide. [ ]  |  |
|  If “yes,” when and how? |       |
| Check if you have thoughts about suicide now. [ ]  |  |
| **Injury to Others** |
| Check if you have ever thought about hurting someone else. [ ]  |  |
|  If “yes,” when was the last time? |       |
| Check if you have ever hurt someone else. [ ]  |  |
|  If “yes,” when and how? |       |
| Check if you are thinking about hurting someone now. [ ]  |  |
| **Recent Stressful Life EventsPlease describe if any of the following events that haveoccurred during the last 2 years.** |
|  Married       |  |
|  Engaged       |  |
|  Separated       |  |
|  Divorced       |  |
|  Serious argument       |  |
|  Breakup of important relationship       |  |
|  child left home       |  |
|  death of spouse, other       |  |
|  bad health (behavior) of family member       |  |
|  difficulties with family member       |  |
|  personal injury, illness       |  |
|  sexual difficulties       |  |
|  difficulties, changes at school, work       |  |
|  retired, lost job       |  |
|  changed residence       |  |
|  legal difficulties, multiple traffic tickets       |  |
|  owe money       |  |

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| **Family History** | **Major Illnesses** |
| **Name** | **Age1** | **Occupation2** | List all major illnesses, including psychiatric, neurologic, alcoholism, drug abuse, suicide, and suicide attempts. |
| **Mother** |  |  |  |  |
|       |  |       |       |       |
| **Father** |  |  |  |  |
|       |  |       |       |       |
| **Brother(s)** |  |
|       |
| **Sisters** |  |
|       |
| **Children** |  |
|       |
| **Grandparents, aunts/uncles** |  |
|       |

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| **Medical History** |
| **Weight and Height** |
| What is your current weight/height in pounds/inches?       |  |
| Please describe the circumstances if your weight has increased or decreased by 10 % or more in the past 6 months |  |
|       |
| **Sleep** |
| Do you have sleep problems? |
| Please describe your problems with sleep (falling asleep waking up, not feeling rested, nightmares, bedwetting etc.) |  |
|       |  |
| **Tobacco Use** |
| Check if you use tobacco products [ ]   |  |
| If checked, how much and for how long? |  |
|       |  |
| **Caffeine** |
| Check if you use caffeine in any form. [ ]  |  |
| If checked, how much? |  |
|       |  |
| **Current Prescription and Over the Counter Medications, Supplements, and Allergies****(Please include doses)** |
|       |

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| **Medical Problems****(Please list all past and present medical problems, the age when they first occurred, any past surgeries or accidents)**  |
|      **Females – Menstrual History**If your periods are irregular, please describe.     Do you experience changes in your thoughts, feelings or behavior in the week before your periods. If so, please explain     If you are taking a hormonal contraceptive (birth control pill, any IUD other than the copper one, implant, vaginal ring, depo shot), which one and have you noticed any impact on your thoughts, feelings or behaviors?      |