INTAKE FORM - CONFIDENTIAL

Patient Information:

Date: _____

Last Name:_____First:_____ MI: _____

Date of Birth:_____Age:_____Sex:_____ SSN: _____

Mailing Address:_____

City/State:_____Zip: _____

Home Phone: (___) ____ - _____ Work: (___) ____ - _____ Marital Status: _____

Name of Person(s) Financially Responsible: _____

Relationship to Patient: _____

Address (if different than patients): _____

City/State:_____Zip: _____

Employer/School Information:

Name:_____ Occupation: _____

Address: _____

City/State:_____Zip: _____

Education/Degrees:_____Grade:_____

Parent/Spouse's Information:

Name:_____ Phone: ( ) _____

Relationship to patient: _____

Employer Name:_____ Work: ( ) _____

Address:_____City/State/Zip: _____

*In Case of Emergency, Contact: _____

Home:_____Work:_____Other:_____

Medical History

Patient Name: _____

Primary Care Physician:

Name of Practice:_____Dr._____

Address:_____ Phone: ( ) _____

Past Diagnoses (please give the year):

1. _____
2. _____
3. _____

Current Medications (include dosage and frequency):

1. _____ 3. _____
2. _____ 4. _____

Known Allergies: _____

_____

Severe Illnesses (childhood to present): _____

_____

Previous Out/In Patient Therapy (please specify which): _____

_____

Stressors affecting you or your family in the past 1 – 2 years:

_____Deaths	_____Job Change	_____Sexual Abuse
_____Births	_____School	_____Broken Relationship
_____Marriage	_____Step-children	_____Unwanted Pregnancy
_____Divorce	_____Separation	_____Substance Abuse
_____Moving	_____Physical Abuse	_____Medial
_____Chronic Illness	_____Other: _____	

Presenting Problems/Reason for Visit: _____

_____