New Patient Intake Form

Staff: Date:

Appt. Date:		Appt: Time:		Provider:	
Caller's Name:			Relationship to patient:		
Patient's Name:			How did you hear about us?		
D.O.B:		Age:	Language(s):		
Phone #:			Email:		
If under 18 yrs of age:	Parents Martial Status:		Custody Holder:		
Dual Consent for Medical/Psych. Treatment?			Legal documentation avaliable?		
Insurance:		Mental Health Coverage:		How is Ins. obtained?	
Chief Compliants/Symptoms:					
Psychiatric Diagnosis:				Date Diagnosised:	
				Provider:	
Medication Name:	Strength/Dosage:	Daily Dose:	Length of Therapy:	Prescriber:	Prescribed for what?
Other Medical Conditions:			Other Medications:		
Currently seeing a Therapist?		Therapist Name:		Length of Therapy:	
Psych. hospitalization?	# times?	When?		Length of Stay(s)?	
Reason(s)?				Facility(s):	
				Voluntary or Involuntary?	
Susbstance abuse (illicit, prescribed, alcohol, tobacco,etc.)?					
If yes, what, how much, and how often?					
Eating Disorder(s)?:		If yes, when?			
Suicidal Ideations?		When?		Frequency?	
Thoughts of harming others?		When?		Frequency?	
Agressiveness?		Verbal or Physical?		When?	
Family History of Mental Illness/Notes:					