

# INITIAL INTAKE FORM

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Therapist name \_\_\_\_\_ Date \_\_\_\_\_

## Identifying Information

Age \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Place \_\_\_\_\_

Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ Height \_\_\_\_ ft. \_\_\_\_ in. Weight \_\_\_\_\_ lbs.

Race: White \_\_\_\_\_ Black \_\_\_\_\_ Asian \_\_\_\_\_ Hispanic \_\_\_\_\_ Other \_\_\_\_\_

Marital Status: M \_\_\_\_\_ S \_\_\_\_\_ D \_\_\_\_\_ W \_\_\_\_\_ Sep \_\_\_\_\_

If married, spouse's name \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Occupation (Spouse) \_\_\_\_\_ Employer \_\_\_\_\_

Referral source: Self \_\_\_\_\_ Other \_\_\_\_\_

Name of referral source \_\_\_\_\_

Address of referral source \_\_\_\_\_

## Treatment History (General)

Are you currently taking medication? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, name(s) of the medication(s) \_\_\_\_\_

Dosage of medication(s) \_\_\_\_\_

Provider of medication(s) \_\_\_\_\_

Have you received previous psychiatric treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, name provider \_\_\_\_\_

Dates of service \_\_\_\_\_ Location \_\_\_\_\_

Reason for termination of treatment? \_\_\_\_\_

Presenting problem or condition (current) \_\_\_\_\_

Presenting factors (contributors) \_\_\_\_\_

Symptoms (describe) \_\_\_\_\_

Acute \_\_\_\_\_ Chronic \_\_\_\_\_

**Family History (General)**

Father's name \_\_\_\_\_ Age \_\_\_\_\_ Living \_\_\_\_\_ Deceased \_\_\_\_\_  
Occupation \_\_\_\_\_ Full-time \_\_\_\_\_ Part-time \_\_\_\_\_

Mother's name \_\_\_\_\_ Age \_\_\_\_\_ Living \_\_\_\_\_ Deceased \_\_\_\_\_  
Occupation \_\_\_\_\_ Full-time \_\_\_\_\_ Part-time \_\_\_\_\_

**Brother(s)/Sister(s)**

Name \_\_\_\_\_ Age \_\_\_\_\_ Living \_\_\_\_\_ Deceased \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Living \_\_\_\_\_ Deceased \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Living \_\_\_\_\_ Deceased \_\_\_\_\_

**Educational History (General)**

	Name of institution	Location	Dates	Degree
Secondary	_____	_____	_____	_____
College	_____	_____	_____	_____
Trade	_____	_____	_____	_____
Graduate	_____	_____	_____	_____

**Employment History (General)**

Title/Description	(From when to when)	Full- or part-time
_____	_____	_____
_____	_____	_____
_____	_____	_____