Patient Intake Forms

Today's Date: ____________

Patient Name: ______________________________ **Age**: _________ **Date of Birth**: ________________________

Gender: ❑ Male ❑ Female **Marital Status**: ❑ Single ❑ Married ❑ Divorced **Occupation:** __________________________

Ethnicity: ❑ White ❑ Asian ❑ Black ❑ Pacific Islander ❑ Hispanic ❑ American Indian ❑ Other: ______________________

Cell #: ________________________ **Home #:** _____________________________ **Work #:** ___________________

Email: (optional) ____

Ok to leave a message on❑ Cell ❑ Home ❑ Work *(Check all that apply)*

Address: ______________________________**City:** _____________________**State:** _______ **Zip Code**: ___________

Highest level of education: ____

Parent / Guardian's Name: (If client is a minor) ____

Cell #: ____ **Home #:** ____________________________________

Ok to leave a message on❑ Cell ❑ Home ❑ Work *(Check all that apply)*

Each person living in Patient's home:

Name: ________________ **Age:** _____ **Name:** _______________ **Age:** ____ **Name:** _______________ **Age:** ______

Name: ________________ **Age:** _____ **Name:** _______________**Age:** ____ **Name:** ________________ **Age:**______

Name: ________________ **Age:** _____ **Name:** _______________ **Age:** ____ **Name:** ________________**Age:** ______

Session fees will be paid by: ❑ Patient/Parent ❑ Wraparound ❑ Shelter ❑ School ❑ CalVCB ❑Other:

____

Contact Name: (*if other than patient*) ____________________________ **Contact#**: ___________________________

Note: *A 24-hour notice of cancellation is required for all scheduled sessions.*

Emergency Contact: _____________________________**Phone #:** ___________________**Relationship to patient:** _________________________

Confidentiality

All information disclosed within sessions is confidential and may not be revealed to anyone without your written permission except where disclosure is allowed / required by law. Disclosure may be required under the following circumstances: Where there is reasonable suspicion of child, dependant or elder abuse; where there is reasonable suspicion that the client presents a danger of violence to others or where the client is likely to harm him or herself unless protective measures are taken. Disclosure may also be required pursuant to a legal proceeding. All identifiable information is kept strictly confidential.

Patient Signature: ____ **Date:** ____________________________

I/we, the undersigned parent(s) or legal guardians(s) of the minor listed above, do hereby give my/our consent for provisions of counseling services to Kathy C. Evans, PsyD, MA, LMFT, Clinical Psychologist / Licensed Marriage & Family Therapist / child, youth and adult Trauma Specialist.

Parent/Guardian's Signature: ___________________________________ **Date:** __________________________

Mental Health Assessment Questionnaire

Have you in the past or do you currently experience any of the following? (Check all that apply)

❑ Tension
❑ Worry too much
❑ Trembling/Sweating
❑ Heart Racing
❑ Obsessive thoughts
❑ Lack of Concentration
❑ Fatigue (lack of energy)
❑ Forgetfulness
❑ Crying Spells
❑ Hopelessness
❑ Lack of Pleasure/Motivation
❑ Suicidal thoughts (wanting to hurt yourself)
❑ Not Eating
❑ Binge Eating
❑ Overeating
❑ Purging
❑ Substance Abuse
❑ Irritability
❑ Uncontrollable anger
❑ Homicidal thoughts (wanting to hurt someone else)
❑ Sleeping Problems
❑ Nightmares or bad dreams
❑ Flashbacks
❑ Hallucinations (hearing voices or seeing things)
❑ Intrusive Thoughts
❑ Impulsive behaviors
❑ Restlessness
❑ High energy (keyed up/can't stop)
❑ Hyperactivity
❑ Sexual concerns

Other: ________________ ________________

Check any areas being affected by the items marked above? ***(Check all that apply)*** ❑Emotionally ❑Mentally ❑Physically ❑Sexually ❑Socially ❑Marriage/Family ❑School ❑Work ❑Legally ❑Other:________________________

Have you experienced any of the following abuses? ***(Check all that apply)***

❑ Emotional ❑Mental ❑ Physical ❑ Sexual ❑ Witnessed another being abused ❑ have abused others

If checked any items above answer the following: When did the abuse occur, for how long and who was the abuser?

____

Place an "X" in the column that best fits for you for each statement.

I…	**Often**	**Sometimes**	**Rarely**
Communicate well with others.			
Get along well with authority figures.			
Get along well with my peers.			
Am able to set goals & work towards them.			
Get support from my family and/or friends.			
Am satisfied with my relationships.			
Understand how to be safe in my intimate relationships.			
Like myself, even when others reject me.			
Can laugh at myself.			
Am happy to be me.			
In my current relationship…	**Often**	**Sometimes**	**Rarely**
We argue and fight about everything.			
When we are together I feel like I am walking on eggshells.			
I feel responsible for our problems.			
Alcohol and/or drugs affect our relationship.			
I feel isolated and depressed.			
I feel controlled by my spouse/partner.			

I have experienced or am currently experiencing…	**Yes**	**No**
Damage to personal relationships and/or have difficulties at work/school due to my anger.		
Legal issues (e.g. traffic tickets, history of arrests, probation, etc.).		
I have or am currently…	**Yes**	**No**
Experiencing legal, financial, health, work, school, family, friendship or relationship problems because of my alcohol and/or drug use.		
Using alcohol or drugs to cope with life.		
Calling myself an alcoholic or addict.		
Being treated for substance abuse.		
Have a family history of substance abuse.		

Place an "X" in the column that best fits for you for each statement.

Previous Mental Health History	**How Long**	**Yes**	**No**
Have you ever received mental health treatment before?			
When and for how long?			
What was the focus of treatment?			
Name of treating therapist(s), address (es), telephone number(s)			
Have you ever been subjected to one or more psychological tests?			
If so, by whom?			
Name of person(s) administered psychological tests, address (es), telephone number(s)			
Have you ever been hospitalized for mental or emotional problems?			
When and for how long?			
Why were you hospitalized?			
Name of treating therapist, address, telephone number			
Are you currently taking any prescription medications? If yes, please include name and dosage of medication.			
Prescribed by whom?			
How long have you been on the medications?			
Have you ever taken any medications for a mental or emotional condition in the past? If yes, please include the name of the medication.			
When and for how long?			
Have you ever attempted suicide? If so, when?			
Describe the circumstances that led to that attempt			
Are you currently having any suicidal thoughts? Please describe			
Please describe your childhood (a sentence or two)			

Areas of Concern			
What issues/concerns causes you to seek treatment? Please describe			
Do you have any specific goals with regard to your treatment?			
Do you have any concerns/fears with regard to treatment?			
Family of Origin History			
Mother's name, age, living/deceased, patient's age at the time of mother's death, description of relationship with mother.			
Father's name, age, living/deceased, patient's age at the time of father's death, description of relationship with father.			
Names and ages of siblings			
Other Information			
Please describe your spiritual orientation			
Please describe your interests/hobbies			
Are you now or have you ever been involved in a lawsuit? ____ Please describe			

Medical History

Physician Name: ______________________ **Phone #:** ______________

Date of Last Medical Exam: ______________

Current Prescription Medications & Dosages: ______________

Current Nonprescription Medications: ______________

Do you currently use any of the following? *(Check all that apply)*

❑ Alcohol ❑ Marijuana/Hash ❑ Inhalants (Paint/Glue/Gasoline/Cleaning supplies etc.) ❑ Pain Killers (Heroin, Methadone, OxyContin, Vicodin, etc.) ❑ Prescription Meds ❑ Crystal Meth ❑Ecstasy ❑ Caffeine ❑ Cocaine ❑ PCP(Angel Dust) ❑ Magic Mushrooms ❑ Special K ❑ LSD ❑ Nicotine (Cigarettes/Cloves) ❑ Anabolic steroids

❑Other: ______________

(Check all that apply and fill-in description)

Past	Present	Condition	Description
		Heart Trouble	
		Shortness of Breath	
		Pain or pressure in chest	
		High Blood Pressure	
		Stomach problems	
		Dizziness or Fainting	
		Diabetes	
		Unusual Bleeding	
		Frequent or Severe Headaches	
		Epilepsy, convulsions, fits	
		Stroke	
		Head Injury	
		Back Problems	
		Kidney Trouble	
		Bedwetting or soiling	
		Hepatitis, jaundice or liver trouble	
		Pregnancy	
		Other Serious Illnesses	
		Suicidal Thoughts/Attempts	
		Hospitalization(s)	
		Psychological Evaluation (s)	
		Mental Illness Diagnosis(s)	

Patient Signature: **Date:**