PARENTING ON CALL

ADULT INTAKE FORM

PATIENT HISTORY

Name: _____ Birthdate: _____
Age: _____ Today's date: _____
Primary phone #: _____
Address:
_____
Highest school grade completed?_____Occupation: _____
Email address:_____
How did you find out about my practice?_____
Marital Status: _____
Religious denomination/affiliation (specify, if applicable): _____
Involvement: ❑ None ❑ Some/irregular ❑ Active
Ethnicity/national origin: _____
Other important identifiers: _____

Emergency contact

If some kind of emergency arises and I cannot reach you directly, whom should I call?
Name: _____ Phone: _____ Relationship: _____
Address:
_____

List names of all people living in household (relationship and age)
_____
_____
_____
_____

Primary language spoken in the home _____

Other languages spoken _____

CHIEF CONCERN

Briefly describe your concerns.
_____
_____
_____
_____
_____
_____

Describe any current marital and/or family stress, if applicable.
_____
_____
_____
_____

AREAS OF CONCERN (check all that apply):

Family Adjustment:
( ) Parent-child problem
( ) Marital conflict or co-parenting problems
( ) Family conflict
( ) Recent family changes
( ) Neighborhood difficulties
( ) Drug or alcohol problems in family
( ) History of trauma or loss
( ) Domestic violence ( ) Abuse ( ) Other (please specify):

Physical/Developmental Factors:
( ) Eating
( ) Sleeping
( ) Toileting
( ) Grooming
( ) Perceptual/visual functions
( ) Language or speech
( ) Motor coordination problems
( ) Other, (please specify):

Personal/Social Adjustment:
( ) Unduly sad
( ) Overly anxious
( ) Overly aggressive
( ) Outbursts of anger
( ) Withdrawn or shy
( ) Disturbing habits or mannerisms
( ) Strange or bizarre behavior
( ) Difficulty with interpersonal relationships
( ) Drug or alcohol problems
( ) Problems with the law
( ) Harms self or others (suicidal or homicidal)
( ) Other (please specify):

MEDICAL HISTORY
From whom or where do you receive medical care?
Clinic/doctor's name: _____ Phone: _____
Address: _____
May I contact your medical doctor so that he or she can be fully informed, and we can coordinate treatment?
❑ Yes ❑ No

Health Insurance Information (I will need to make a copy of your card(s))

Name of Primary insurance company:_____
Primary Subscriber's Name, Date of Birth, and Address:_____
Member ID number:_____ Group number (if applicable):_____

Name of Secondary insurance company:_____
Primary Subscriber's Name, Date of Birth, and Address:_____
Member ID number:_____ Group number (if applicable):_____

Social-Emotional
How would you describe yourself?
_____
_____
What do you like/appreciate/value most about yourself?
_____
_____
List activities you enjoy.
_____
_____

Abuse History:

Have you ever been the victim of abuse or neglect? Yes No

If yes, what was the nature of the abuse? **(Please circle all that apply.)**
Physical Emotional Neglect Accidents Disasters Sexual Witnessing violence Other:

Are you struggling with your marital relationship or parenting? Yes No
If yes, please describe:
_____

PRIOR TREATMENT
Have you been in therapy or seen a psychiatrist in the past? If yes, please list: _____
_____

Previous history: Have you ever been treated for any of the following (check all that apply):

____ Depression	_____ADHD	____ Bipolar (Manic / Depressive) Disorder
____ Anxiety	_____OCD	____ Schizophrenia
____ Panic Attacks	_____PTSD	____ Alcohol Problems (including AA)
____Anorexia/ Bulimia	_____Binge-eating	_____ Drug Problems

Please list in chronological order all prior psychiatric hospitalizations (if any) below:

Approximate Date	Length of Stay	Name of Hospital	Reason for Admission

Have you ever attempted to harm/kill yourself? If so, please list the occurrences below:

Approximate Date of Attempt	Method of Attempt

Please List *all* current medications below (include birth control pills, over the counter medication and herbal remedies (i.e., decongestants, St. John's Wort etc.)

Name of Medication	Dosage	How many times daily?	How long on medication?	Side Effects (if any)	Prescribing physician