Patient Intake Form

_____

Last Name First Name Middle Name

Date of Birth: _____

Social Security Number: _____

Home Phone: _____

Cell Phone: _____

E-mail: _____

Occupation _____

Employer: _____

Marital Status: _____

Home Address: _____

Emergency Contact: _____

Name Phone number

Referred by: _____

Primary Care Physician: _____

Psychotherapist: _____

Reason you are seeking treatment:

What are your treatment goals?

Current Weight _____

Current Height _____

Allergies: _____

Current Medical Problems: _____

Past Medical Problems: _____

Surgeries: _____

Please list **all** current prescription medications (if none, please write none):

Medication Name	Total Daily Dosage	Estimated Start Date

Current over-the-counter medications: _____

Current supplements: _____

Date and place of last physical exam:_____

Do you exercise regularly? ( ) Yes ( ) No

On average, how many hours of sleep do you get each night? _____

Do you have difficulty falling asleep? ( ) Yes ( ) No

Do you regularly experience awakenings during the night? ( ) Yes ( ) No

If yes, how many awakenings do you experience per night? _____

If yes, how long have you been experiencing this problem for? _____

Is your sleep regularly poor or unrefreshing? ( ) Yes ( ) No

If yes, how long have you been experiencing this problem for? _____

Do you awake in the morning earlier than you would like? ( ) Yes ( ) No

If yes, how long have you been experiencing this problem for? _____

Do you spend a lot of time thinking about and trying to lose weight? _____

Do you often feel out of control when eating? _____

Do you ever engage in risky behavior (e.g., fasting, over-exercising, vomiting, laxative use, taking diet pills, etc.) in order to lose weight or to maintain your current weight? ( ) Yes ( ) No

Do you eat large amounts of food when you are not hungry? ( ) Yes ( ) No

How much caffeine do you drink every day? _____

How much alcohol do you drink every week? _____

Do you smoke? ( ) Yes ( ) No

If yes, how many cigarettes do you smoke each day, on average? _____

Do you use marijuana? ( ) Yes ( ) No

If yes, how much marijuana do you use each day, on average? _____

For women:

Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No

Are you planning to get pregnant in the near future? ( ) Yes ( ) No

Birth control method _____

How many times have you been pregnant? _____ How many live births? _____

Personal/Family Medical & Psychiatric History (Place a Check Mark Below All that Apply)

	You	Mother	Father	Sibling(s)	Aunts/Uncles/Cousins
Anemia					
Anxiety					
Asthma					
Autism Spectrum Disorder					
Bipolar Disorder					
Cancer					
Chronic Fatigue Syndrome					
Chronic Pain					
Dementia					
Depression					
Diabetes					
Fibromyalgia					
GI Disease					
Head Trauma					
Heart Disease					
Kidney Disease					
Liver Disease					
Obsessive-Compulsive Disorder					
Panic Disorder					
Personality Disorder					
Post-Traumatic Stress Disorder					
Schizophrenia					
Seizures					
Substance Abuse					

Other (please describe):

Have you ever seen a physician (psychiatrist or otherwise) for medication management? If so, please provide the dates during which you were treated, state what the diagnosis was, name the medications you were prescribed, and indicate the dose of the medication you were on.

Dates (From, To)	Diagnosis	Medication	Dose

Have you ever undergone psychotherapy before? Please state the dates during which you received psychotherapy, the diagnosis you received, and the type of therapist you worked with (e.g., psychiatrist, psychologist, social worker, etc.).

Dates (From, To)	Diagnosis	Type of Therapist

Have you ever been hospitalized for psychiatric reasons? If so, please provide the date that your hospitalization began, the duration of the hospitalization, the name of the hospital, the diagnosis or diagnoses you received, and the medication(s) you were treated with during the hospitalization.

Date	Duration	Hospital	Diagnosis	Medication(s)

Have you ever attempted suicide? ( ) Yes ( ) No

If yes, what was/were the date(s) of the suicide attempt(s)?

Date(s)

Have you ever engaged in cutting behaviors? ( ) Yes ( ) No

If yes, please provide the dates of onset and cessation (if one exists) of those behaviors.

From	To