# INTAKE FORMS

*Please provide the following information and answer the questions below. Please note:*
*Information you provide here is protected as confidential information.*
*Please fill out this form and bring it to your first session.*

Name: _____
(Last) (First) (Middle Initial)
Name of parent/guardian (if under 18 years):
_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female
Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated
□ Divorced □ Widowed
Please list any children/age:
_____
_____
Address:
(Street and Number)
_____
_____
(City) (State) (Zip)
Home Phone: _____ May we leave a message? □Yes □No
Cell: _____ May we leave a message? □Yes □No
Work Phone: _____ May we leave a message? □Yes □No
E-mail: _____ May we email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.
Referred by (if any):
_____
Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner:
_____
Are you currently taking any prescription medication?
□ Yes
□ No
Please list:
_____
_____
Have you ever been prescribed psychiatric medication?
□ Yes
□ No
Please list and provide dates:

_____
_____
GENERAL HEALTH AND MENTAL HEALTH INFORMATION
1. How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific health problems you are currently experiencing:
_____
2. How would you rate your current sleeping habits? (Please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific sleep problems you are currently experiencing:
_____

3. How many times per week do you generally exercise? _____
What types of exercise to you participate in: _____?
4. Please list any difficulties you experience with your appetite or eating patterns.
_____
_____
5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes
If yes, for approximately how long? _____
6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes
If yes, when did you begin experiencing this? _____
7. Are you currently experiencing any chronic pain?
□ No
□ Yes
If yes, please describe? _____
8. Do you drink alcohol more than once a week? □ No □ Yes
9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never
10. Are you currently in a romantic relationship? □ No □ Yes
If yes, for how long? _____
On a scale of 1-10, how would you rate your relationship? _____
11. What significant life changes or stressful events have you experienced recently?
_____
12. Have you ever been hospitalized for any emotional or psychiatric illness? If so, for what and how long?
_____
13. Have you, are you presently or will you be involved in legal proceedings? If so, for what and how long?
_____
14. Do you ever hear voices in your head or see things which other people can't see? If so, when?
_____
FAMILY MENTAL HEALTH HISTORY:
In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).
Please Circle List Family Member
Alcohol/Substance Abuse yes/no
Anxiety yes/no
Depression yes/no
Domestic Violence yes/no
Eating Disorders yes/no
Obesity yes/no
Obsessive Compulsive Behavior yes/no
Schizophrenia yes/no
Suicide Attempts yes/no

ADDITIONAL INFORMATION:
1. Are you currently employed? □ No □ Yes
If yes, name and address of your employer:
_____
_____
Do you enjoy your work? Is there anything stressful about your current work?
_____
_____
2. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:
_____
3. What do you consider to be some of your strengths?

_____
_____

4. What do you consider to be some of your weakness?

_____
_____

5. What would you like to accomplish out of your time in therapy?

_____
_____

**I, Print Name, _____have indicated to the best of my knowledge that the information I provided on this intake form is true and accurate.**

_____ _____

**Signature** **Date**

**HEALTH INSURANCE INFORMATION**

If you are using or may use in the future, health insurance, the following information is necessary in order to bill the insurance company. *PLEASE BRING COPY OF INSURANCE CARD TO THE SESSION!

PATIENT INFORMATION:

1. PATIENT'S FULL NAME _____
2. STREET ADDRESS _____
3. CITY _____
4. STATE & ZIP CODE _____
5. PATIENT'S DATE OF BIRTH _____
6. TELEPHONE _____
7. PATIENT'S SEX M_____ F_____
8. PATIENTS' RELATIONSHIP TO INSURED:
   SELF___ SPOUSE____ CHILD_____ OTHER_____
9. PATIENTS' STATUS:
   SINGLE____ MARRIED___ OTHER_____
   EMPLOYED_____ FULL-TIME STUDENT_____ PART-TIME
   STUDENT_____
10. SOCIAL SECURITY # _____

INSURED'S INFORMATION (the "insured" is the person who owns the policy or is the employee to whom a group policy is applicable)

1. NAME OF INSURED _____
2. STREET ADDRESS OF INSURED _____
3. CITY _____
4. STATE & ZIP CODE _____
5. INSURED'S DATE OF BIRTH _____
6. SOCIAL SECURITY # _____
7. TELEPHONE _____
8. INSURED'S PLACE OF EMPLOYMENT: _____
9. INSURANCE PLAN NAME OR PROGRAM NAME. _____
10. INSURED'S INSURANCE ID NUMBER_____
11. POLICY GROUP NUMBER _____

I authorize the release of any medical or other information necessary to process insurance claims. I further authorize the payment of medical or insurance benefits to Patrick Andretta, PhD, to obtain or release therapy records and treatment plans to my insurance company for the purpose of evaluation, treatment and payment.

_____ Date _____

Signature of Insured

**MEDICAL HISTORY**

Please complete: This is very important information. Please feel free to add any additional information that you feel is needed.

Name_____

Current Physician and/or Primary Care Physician_____

Address:_____City_____Zip_____

Phone:_____

Medications prescribed by this M.D. (Name and dosage)_____

_____

_____

Are you are under the care of a psychiatrist? Yes_____ No_____

Name of Psychiatrist or Psychiatric Nurse _____

Address:_____City:_____Zip_____

Medication and dosage prescribed by Psychiatrist:_____

_____

Have you been hospitalized for emotional problems? Yes_____-No_____

If so: When_____Where_____

Have you had previous individual therapy? Yes____No_____ Dates:_____

Name of Therapist:_____Address:_____

City:_____Zip_____Telephone_____

Name of Therapist:_____Address:_____

City:_____Zip_____Telephone_____

Have you been treated for substance abuse? Yes _____Date: _____

Are you being treated now for substance abuse? Yes _____No_____

Please list any and all physical illnesses that are now being treated by M.D.

_____

_____

_____

_____

What would you want your therapist to know about your physical or emotional health:_____

_____

_____

_____

I authorize Patrick Andretta, PhD to contact by telephone or mail the following medical professionals for the purpose of consulting and coordinating care for my therapy and treatment.

Name_____Address:_____

City:_____State_____Zip_____

Phone: ( )_____Fax: ( ) _____

Name_____Address:_____

City:_____State_____Zip_____

Phone: ( )_____Fax: ( )_____

_____Date_____

Authorization Signature

_____Date_____

Your Signature