Grinstead, Pierce & Associates

Real Solutions to Fit Your Needs

Intake Form

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.

Patient Information

Patient Name:

_____

(Last) (First) (Middle Initial)

**If under 18 years old* - Name of parent/ guardian of patient:

_____

(Last) (First) (Middle Initial)

Patient Social Security # __ __ __ - __ __ - __ __ __ __ Birth Date: __ __ / __ __ / __ __ Age:_____

Address: _____

Street City State Zip

Mailing address if different from above: _____

Home Phone: ( ) May we contact you or leave a message? ☐ Yes ☐ No

Cell/Other Phone: ( ) May we contact you or 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.*

If no contact is requested, please explain: _____

I was referred by: _____

How did you hear about us? _____

Emergency Contact for patient:

_____(____)_____

First and last name Relationship Phone Number

Insurance Information:

Policy Holder Name: _____ Birth date: _____

Address (if different from client) _____

Medical Insurance Company _____ Employer_____

EAP/Mental Health Company (if different from above) _____

Insurance ID number or Social Security Number (if EAP or Private Pay): _____

Relationship to Client _____

Is there secondary Insurance? _____

Please complete if client is a minor:

Father's Name _____ Social Security Number _____

Father's Address _____ Phone Number _____

Employer _____ Date of Birth _____ Work Phone _____

Mother's Name _____ Social Security Number _____

Mother's Address _____ Phone Number _____

Employer _____ Date of Birth _____ Work Phone _____

List name and phone number of Primary Care Physician (PCP): _____

By signing below, ***I AUTHORIZE THE RELEASE OF INFORMATION*** necessary to process my insurance/ EAP/ managed care/ DDS claim and ***I ACKNOWLEDGE FINANCIAL RESPONSIBILITY*** for this account.

CLIENT SIGNATURE _____ DATE_____

AUTHORIZED SIGNATURE FOR A MINOR _____ DATE_____

Name_____ Date of Birth _____

PRESENTING PROBLEM:

I am seeking help for (please check all that apply):

☐ Anxiety ☐ Alcohol problem ☐ Depression ☐Domestic violence/Abuse
☐ Drug problem ☐ Gambling problem ☐ Trauma/Abuse ☐ Job problems
☐ Legal problems ☐ Relationship problems ☐ School problems ☐ Not sure ☐ Other

Brief description: _____
Impact on functioning: _____

BACKGROUND INFORMATION

IDENTIFICATION:

Currently: ☐Never Married ☐Domestic Partnership ☐Married ☐Separated ☐Divorced ☐Widowed

If applicable, How long have you been in your current relationship? _____ Months _____ Years

On a scale of 1 – 10, circle satisfaction with current relationship: *(low satisfaction)* 0 1 2 3 4 5 6 7 8 9 10 *(high satisfaction)*

Please give name, age and sex for each of your children: ☐ No children

Name of each child:					
Age:					
Sex:					
Biological:					
Step-child:					
Custody status:					

Race/Ethnicity: _____ ☐ I choose not to answer
Do you believe anything in your cultural background would create a barrier to treatment? ☐ Yes ☐ No
Brief description: _____

Do you consider yourself to be spiritual or religious? ☐No ☐Yes, Religion/Belief: _____

Gender: ☐ Male ☐ Female ☐Androgynous ☐Gender neutral ☐Transgender ☐Other ☐Prefer not to answer

HISTORY OF PRESENTING PROBLEM:

What significant life changes or stressful events have you experienced recently: _____
_____

Mild = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and/or day-to-day functioning
Severe = Profound impact on quality of life and/or day-to-day functioning

Symptoms unchecked will be considered not applicable.

Patient's *current* symptoms. Please check √ all that apply:	Mild	Moderate	Severe	Symptoms continued. Please check √ all that apply:	Mild	Moderate	Severe
Aggressive behaviors				Laxative/diuretic abuse			
Agitation/Irritability				Lightheaded			
Anger				Loss of touch with reality			
Anorexia				Low esteem			
Anxiety (generalized)				Mood swings			
Appetite disturbance				Muscle tension			
Bingeing/purging				Nausea			
Circumstantial symptoms				Nightmares			
Conduct problems				Obsessions/Compulsions			
Delusions				Oppositional behavior			
Depressed mood				Overly talkative			
Perception/sensations of world seems unreal				Panic attacks			
Difficulty making decisions				Paranoid thinking			
Dizziness				Phobias (fears)			
Elevated mood (Mania)				Poor hygiene			
Elimination (toileting) disturbance				Psychomotor retardation			
Emotionality				Related medical conditions			
Fatigue/low energy				Restlessness			
Feeling of choking				Seeking excessive pleasure			
Flashbacks				Self-mutilation			
Racing/Rapid thoughts				Sexual dysfunction			
Forgetfulness				Significant weight gain/loss			
Grief				Sleep disturbance			
Guilt				Social isolation			
Hallucinations				Somatic complaints			
Hopelessness				Tremble or shake			
Hyperactivity				Trouble concentrating/Distractibility			
Impulsiveness				Trouble with daily living activities			
Intrusive thoughts				Worthlessness			
Invincibility							

Symptoms unchecked will be considered not applicable.

PAST PSYCHIATRIC HISTORY:

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐No ☐Yes, name of your *Psychiatrist/Psychologist*? _____

FAMILY HISTORY:

Describe your childhood family experience:

☐ Outstanding home environment ☐ Normal home environment ☐ Chaotic home environment

☐ Witnessed physical/verbal/sexual abuse toward others ☐ Experienced physical/verbal/sexual abuse from others

People in your family who were important as you grew up: _____

Father: ☐ Living ☐ Deceased How do you get along?: _____

Mother: ☐ Living ☐ Deceased How do you get along?: _____

Siblings and how do you get along:_____

FAMILY PSYCHIATRIC HISTORY:

Mental health history. Please check √ all that apply:	**Self (Patient)**		Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents	Maternal Aunts/Uncles	Paternal Aunts/Uncles
Alcohol/Substance Abuse									
Anxiety									
Behavioral Problems									
Dementia									
Depression									
Domestic Violence									
Eating Disorder									
Emotional Problems									
Gambling Addictions									
Mental Retardation									
Obsessive Compulsive Disorder (OCD)									
Schizophrenia									
Suicide Attempts									
Other Mental Illness									

MEDICAL CONDITIONS & HISTORY:

How would you rate your current physical health? ☐ GOOD ☐ FAIR ☐ POOR

Medical History: In the section below, identify if there is a history of any of the following:

Medical health history. Please check √ all that apply:	**Self (Patient)**	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents	Maternal Aunts/Uncles	Paternal Aunts/Uncles
Allergic reaction								
Alzheimer's								
Birth defects								
Cancer								
Diabetes								
Heart disease								
High blood pressure								
Obesity								
Stroke								
Thyroid problems								
Tobacco use								
Tuberculosis								
Chronic pain								
Other* chronic or serious health issue								

If other*, please provide any important information or history:

_____

_____

Please describe any significant illnesses, hospitalizations or accidents you have had:

_____

_____

_____

Please list any specific health problems you are currently experiencing: _____

_____

CURRENT MEDICATION:

Please provide a current list/copy of all medications or complete the following:

Have you ever been ***prescribed psychiatric*** medication? ☐No ☐Yes if yes, please list information:

Medication	Dosage	Frequency	Reason	Prescribing Doctor

Are you currently taking **any *prescription*** medication? ☐No ☐Yes if yes, please list information:

Medication	Dosage	Frequency	Reason	Prescribing Doctor

SUBSTANCE USE/ABUSE:

How often do you engage in recreational (illicit/non-prescribed) drug use?

☐ Never ☐ Infrequently ☐ Monthly ☐ Weekly ☐ Daily

SOCIAL HISTORY:

My social support system is: ☐ a supportive network ☐ few or no friends ☐ substance abuse friends ☐ distant from family of origin

My living/housing situation is: ☐ Adequate ☐ Overcrowded ☐ Homeless ☐ Dependent on others ☐ Dangerous/deteriorating ☐ Living companion(s) are dysfunctional

My financial situation includes: ☐ No problems ☐ Large indebtedness ☐ Poverty or below-poverty income ☐ Impulsive spending ☐ Relationship conflicts over finances

Sexual orientation? ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Straight/Heterosexual ☐Other ☐Prefer not to answer

Are you currently sexually active? ☐ Yes ☐ No ☐ I use protection/birth control Sexually ☐ Satisfied ☐ Dissatisfied

EDUCATIONAL/OCCUPATIONAL HISTORY:

Current Employment: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Volunteer work ☐ Homemaker ☐ Student

Current or highest education level completed: K 1 2 3 4 5 6 7 8 9 10 11 12 ☐ GED

☐ Some college ☐ College degree completed: _____ ☐ Other: _____

Current School or College (if applicable):_____

Grades achieved were: ☐ GOOD ☐ FAIR ☐ POOR

Name of Employer (if applicable) _____

On a scale of 1 – 10, circle current job satisfaction: *(low satisfaction)* 0 1 2 3 4 5 6 7 8 9 10 *(high satisfaction)*

Describe the work you do: _____

Length of employment: _____

Relationship with co-workers(s): ☐ GOOD ☐ FAIR ☐ POOR

Relationship with Supervisor(s): ☐ GOOD ☐ FAIR ☐ POOR

Do you enjoy your work? Is there anything stressful about your current work? _____

☐ Served in military ☐ no-incident ☐ with incident Branch _____

LEGAL HISTORY:

Have you ever been arrested? ☐ No ☐ Yes – if yes, please provide details:

☐ Arrest(s) NOT substance related, how many times? _____ ☐ Non-violent offense ☐ Violent offense

☐ Arrest(s) substance related, how many times? _____

☐ I am currently on probation/parole

☐ I am currently in drug court

☐ My charge was related to a domestic violence offense

☐ I have served time in jail/prison. Total time served? _____

STRENGTHS:

What do you consider your strengths? _____

LIMITATIONS:

What do you consider your Limitations? _____

What would you like to accomplish or set as a goal(s) to achieve in therapy? _____

_____

_____

As the therapist, I have reviewed and discussed the information provided by the client above and I have clarified information and requested additional details when necessary to provide therapy.

_____ _____

Therapist signature Therapist printed name