the healthy mind

Patient Intake Form

Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy sessions.

General Information

Patient's Name: _____ Date of Birth: _____ Age: ____

Gender: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Preferred Contact Method: **[ ] Home Phone [ ] Cell Phone**

Emergency Contact 1: _____ _____ _____
Name *Relationship* *Phone*

Emergency Contact 2: _____ _____ _____
Name *Relationship* *Phone*

How Did You Hear About Us / Who Referred You: _____

Family and Relationship History

Are you currently:
[ ] Married [ ] Partnered / Relationship [ ] Divorced [ ] Singled [ ] Widowed

What is your sexual orientation? _____

Describe your relationship with your significant other: _____

Do you have children? **[ ] Yes [ ] No** If yes, what are their ages: _____

Describe your relationship with your children: _____

List everyone who currently lives with you: _____

Bergen County Psychology and Psychoeducational Evaluation Center
info@healthymindnj.com
www.healthymindnj.com

Educational History

Highest grade completed through high school: _____ Where? _____

Did you attend college? _____ Where? _____

What is your highest education level or degree attained? _____

Occupational History

Are you currently: **[ ] Working [ ] Student [ ] Unemployed [ ] Disabled [ ] Retired**

What is your occupation? _____ Where do you work? _____

How long in your present position? _____ _____

Please list any work related stressors: _____

Religious and Spiritual Life

Do you belong to a particular religion or spiritual group? If so, which: _____

What is your level of involvement? _____

Do you find your involvement helpful for your mental health or does it make things more difficult or stressful for you? **[ ] Helpful [ ] Stressful**

Reasons for Referral

What are the difficulties or symptoms for which you are seeking help and when did they begin?

_____

_____

_____

Bergen County Psychology and Psychoeducational Evaluation Center
info@healthymindnj.com
www.healthymindnj.com

the healthy mind

What areas of your life are most affected and how? (i.e. relationships, work, home)

_____

_____

_____

What are your treatment goals?

_____

_____

_____

Current Symptoms Checklist (check all that apply, check twice for major symptoms):

[ ] Depressed mood
[ ] Unable to enjoy activities
[ ] Sleep pattern disturbance
[ ] Loss of interest
[ ] Concentration / forgetfulness
[ ] Change in appetite
[ ] Excessive guilt
[ ] Fatigue
[ ] Racing thoughts
[ ] Impulsivity
[ ] Increased risky behavior
[ ] Decreased libido
[ ] Difficulty sleeping
[ ] Excessive energy
[ ] Increased irritability
[ ] Crying spells
[ ] Excessive worry
[ ] Anxiety attacks
[ ] Avoidance
[ ] Hallucinations
[ ] Suspiciousness
[ ] Mood swings
[ ] _____
[ ] _____

Please list ALL current prescription medications and how often you take them (if none, write none):

_____

_____

_____

Bergen County Psychology and Psychoeducational Evaluation Center
info@healthymindnj.com
www.healthymindnj.com

the healthy mind

Psychiatric History

Do you currently or have you ever seen a psychiatrist, psychologist or therapist? **[ ] Yes [ ] No**
If yes, please describe when, who, for what reason and your diagnosis:

_____

_____

_____

Have you ever been hospitalized for psychiatric treatment? **[ ] Yes [ ] No**
If yes, please describe when, where and for what reason:

_____

_____

_____

Please provide any pertinent family psychiatric history:

_____

_____

_____

How often do you drink? [ ] Daily [ ] 3-5 days a week [ ] Weekends [ ] Seldom [ ] Never

Recreational drug use? [ ] Daily [ ] 3-5 days a week [ ] Weekends [ ] Seldom [ ] Never
If yes, which drugs?

_____

Do you have a history of substance abuse? [ ] Yes [ ] No
If yes, please describe:

_____

_____

Bergen County Psychology and Psychoeducational Evaluation Center
info@healthymindnj.com
www.healthymindnj.com

the healthy mind

Is there anything else you would like for us to know about you?

_____

_____

_____

Signed: _____
Patient (if older than 18)

Signed: _____
Parent, Sole Legal Guardian (if patient is under 18)

Signed: _____
Other Parent (if joint custody of minor)

Date: _____

Bergen County Psychology and Psychoeducational Evaluation Center
info@healthymindnj.com
www.healthymindnj.com