C2 Your Health, PC

Intake Form for Adults

Patient's Name: _____ Today's date: _____

DOB: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Emergency Contact: _____
(Name) (Relationship) (phone number)

Who referred you? _____

Why did you seek out our services?_____

_____

_____

Have you ever been in psychotherapy before?	YES	NO
Have you ever taken medications for your mental/emotional health?	YES	NO
Have you ever had a psychological / neurological / academic evaluation?	YES	NO
Do you have a history of criminal behavior?	YES	NO
Have you had ever had suicidal thoughts?	YES	NO
Have you ever wanted to seriously hurt someone else?	YES	NO
Have you ever been significantly maltreated or traumatized? *(eg, sexually / physically abused, neglected, witness to violence / death, been in serious car accident)*	YES	NO
Have you ever significantly maltreated someone else? *(eg perpetrator of sexual / physical abuse, caused significant bodily or emotional harm)*	YES	NO
Do you currently uses alcohol or drugs (including tobacco)? Is yes, please specify: _____	YES	NO
Are you concerned about your weight / physical health?	YES	NO

List all current prescribed medications:

Name: _____ Purpose: _____

Name: _____ Purpose: _____

Name: _____ Purpose: _____

Name: _____ Purpose: _____

List any major medical / physical conditions: _____

_____

_____

Current Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed

List all immediate family members:

Name:	Relationship:	DOB:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*(Place a * next to every person who lives with you)*

Briefly describe any concerns you have regarding your emotional health, family, or employment:

_____

_____

_____

_____

_____

_____