# Patient Intake Questionnaire

*Please complete and sign where appropriate.*

## Section I - Identifying Information

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Work Phone _____ Ext _____

Cell Phone _____ Pager # _____

Email Address _____

Date of Birth _____ Social Security Number _____

Marital Status _____ Gender ☐ Male ☐ Female

Employer or School _____ Employment Status/Grade _____

Referred By _____

Is the patient covered by insurance? ☐ Yes - Go to section II

☐ No - Go to section V

## Section II - Insurance Information

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

If "Patient Relationship to insured" is other than "Self" please complete the following. If patient is the insured go directly to section III.

Insured's Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Work Phone _____ Ext _____

Cell Phone _____ Pager # _____

Email Address _____

Date of Birth _____ Social Security Number _____

Marital Status _____ Gender ☐ Male ☐ Female

Employer or School _____ Employment Status/Grade _____

## Section III - Insurance Policy Information

☐ Medicare ☐ Medicaid ☐ ChampUS ☐ ChampVA ☐ Group Health Plan ☐ FECA ☐ Other

Insurance Company _____

Address _____

Address _____

City _____ State _____ Zip _____

Plan Name _____

Policy Number _____ Group Number _____

Is the patient covered by more than one insurance? ☐ Yes – Please, complete Section IV

☐ No – Go to PATIENT HEALTH HISTORY Page 3

## Section IV - Secondary Insurance Policy Information

☐ Medicare ☐ Medicaid ☐ ChampUS ☐ ChampVA ☐ Group Health Plan ☐ FECA ☐ Other

Insurance Company _____

Address _____

Address _____

City _____ State _____ Zip _____

Plan Name _____

Policy Number _____ Group Number _____

## Section V - Billing Information

(Complete only if there is no insurance coverage.)

Who is responsible for charges for this patient? ☐ Patient - Go to PATIENT HEALTH HISTORY Page 3

☐ Other - Please complete the following information

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Work Phone _____ Ext _____

Cell Phone _____ Pager # _____

Email Address _____

Date of Birth _____ Social Security Number _____

Marital Status _____ Gender ☐ Male ☐ Female

Employer or School _____ Employment Status _____

# General and Mental Health Information

1. How would you rate your current physical health? (Please circle one)

   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 one)

   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 do you participate in? _____
4. Please list any difficulties you experience with your appetite or eating problems: _____

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? ☐ No ☐ Yes

   If yes, for approximately how long? _____
6. Are you currently experiencing anxiety, panics 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 If yes, please describe: _____
9. How often do you engage in 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 (with 1 being poor and 10 being exceptional), how would you rate your relationship? _____
11. What significant life changes or stressful events have you experienced recently? _____

_____

_____

_____

_____

## 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 (e.g. father, grandmother, uncle, etc.)*

| | | List Family Member(s): |
|---|---|---|
| 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, what is your current employment situation? _____

   _____

   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 weaknesses? _____

   _____

   _____

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

   _____

   _____

   _____