INTAKE REGISTRATION

Patient's Name:______________________________ Today's Date:______________

Hm. address:______________________________ City/St______________ Zip__________

May we mail to above address? Y N Mailing addr :______________________________

Home Phone: (_____)______________________ Work Phone: (_____)______________________

Cell Phone: (_____)______________________ Email:______________________________

May we leave messages for you at home [Y N], work [Y N], cell [Y N]?

Birthdate: ____________ Age: ______ Gender: M____ F____ Soc. Sec. #: ______________

Marital Status: _____Single _____Married _____Separated _____Divorced _____Other

Others living in the home (include names, birthdates & relationship to patient): ______________________________

____

Referred by:______________________________

Primary Physician:______________________________ Phone: (_____)______________

Address:______________________________ City/St______________ Zip__________

Emergency contact Person______________________ Phone: (_____)______________

Primary Insurance Co.:______________________ Ins. Co. Phone: (_____)______________

Insurance Co. Address:______________________ City/St______________ Zip__________

I.D. #:______________________ Group #:______________ Co-Pay Amt.:__________

Policyholder's Name & Addr: ______________________________

Policyholder's Birthdate:__________ Soc. Sec. #: ______________ Phone #: (_____)______________

Policyholder's Employer: ______________________________

Secondary Insurance Co.:______________________ Ins. Co. Phone: (_____)______________

Insurance Co. Address: ______________________ City/St______________ Zip__________

I.D. #: ______________________ Group #: ______________ Co-Pay Amt.: __________

Policyholder's Name & Addr: ______________________________

Policyholder's Birthdate: __________ Soc. Sec. #: ______________ Phone #: (_____)______________

Policyholder's Employer: ______________________________

For Office Use Only D:__________ CPT:__________ EMP: ______________________ THPST: __________

Form BPG-3 Rev 3-05

PATIENT NAME:______________________________ Soc. Sec. #:______________

HEALTH CARE INFORMATION:

When did you last see a physician?________________Why?____________________

What is the date of your last physical examination?____________________

Current health problems:____________________

Hospitalizations or major medical problems:____________________

____

Allergies:____________________

Adverse reactions to medication(s)?____________________

____

CURRENT MEDICATIONS:

Medication	Dosage	Frequency	Date Began	Reason

PREVIOUS MEDICATIONS FOR MENTAL HEALTH DISORDERS:

Medication	Dosage	Frequency	Date Began	Reason

PREVIOUS COUNSELING:

	Reason	Counselor	Dates	Outcome
1.				
2.				
3.				

SUBSTANCE USE HISTORY:

Do you use/have you used tobacco?___Never ___Past ___Currently. Frequency of use:___ per/day wk mo yr

Do you use/have you used alcohol?___Never ___Past ___Currently. Frequency of use:___ per/day wk mo yr

How much caffeine do you use, including cola drinks? ________________per/day wk mo yr

Do you use/have you used recreational drugs? ___Never ___Past ___Currently

Drug(s) of choice:______________________ Frequency of use:___ per/day wk mo yr

EDUCATION:

Patient's Education: ___Elementary ___H.S. ___G.E.D. ___Trade Sch. ___College ___Grad. Sch.

EMPLOYMENT:

Your job title:____________________Employer's Name:____________________

Partner's job title:____________________ Employer's Name:____________________

PATIENT NAME: ____________________ DATE: __________

Describe the problem that brought you here today:

____

____

____

____

____

____

What prompted you to come in now? ______________________

Check those items below that describe your experience in the past month.
Circle those items below that describe your experience in the past one to five years:

Dt. Began		Dt. Began		Dt. Began	
______	☐ Extreme sadness	______	☐ Problematic Internet Use	______	☐ Often relive traumatic memories
______	☐ Poor appetite	______	☐ Increased activity	______	☐ Compulsive behaviors
______	☐ Increased appetite	______	☐ Shortness of breath	______	☐ Fear Intimacy
______	☐ Lack of enjoyment of usual activities	______	☐ Wake up too early	______	☐ Fear leaving house
______	☐ Trouble performing job	______	☐ Dizzy/faint	______	☐ Fear closed in places
______	☐ Poor concentration	______	☐ Startle easily	______	☐ Experience trembling/shaking
______	☐ Perfectionism	______	☐ Feel fatigued	______	☐ Memory problems
______	☐ Frequent worry	______	☐ Go on buying sprees	______	☐ Lack motivation
______	☐ Anger problems	______	☐ Feel empty	______	☐ Feel shy often
______	☐ Tearfulness	______	☐ Excessive perspiration	______	☐ Procrastinate often
______	☐ Crying spells	______	☐ Fear I'm dying	______	☐ Unable to relax
______	☐ Excessive sleep	______	☐ Feel restless	______	☐ Experience bizarre unwanted thoughts
______	☐ Weight changes	______	☐ Have distressful memories	______	☐ Trouble swallowing
______	☐ Change in sexual function	______	☐ Feel detached	______	☐ Problematic gambling
______	☐ Thoughts of harming self	______	☐ Avoid certain thoughts/feelings	______	☐ Experience flushes and chills
______	☐ Thoughts of harming others	______	☐ Frequent nightmares	______	☐ Frequent jealous feelings
______	☐ Feeling nervous	______	☐ Avoid social situations	______	☐ Stay up for days without sleeping
______	☐ Panic suddenly	______	☐ Low self-esteem	______	☐ Experienced physical abuse
______	☐ Feel excessive guilt	______	☐ Bulimia	______	☐ Lose periods of time
______	☐ Easily irritated	______	☐ Easily hurt by criticism		
______	☐ Lack energy	______	☐ Recent loss(es)		
______	☐ Racing thoughts	______	☐ Marital problems		
______	☐ Indecisiveness	______	☐ Difficulty trusting others		
______	☐ Sleep difficulties	______	☐ Experienced emotional abuse		
______	☐ Hear voices	______	☐ Numbness/tingling		
______	☐ Experienced sexual abuse	______	☐ Recurring dreams		

What have you tried to remedy the situation? ______________________