INTAKE FORM

Thank you for taking the time to completely fill out this form as it will help us to better understand you and your situation. The information you provide here is confidential and will only be shared with your clinician.

IDENTIFYING INFORMATION				
Name	Last	First	Middle	
Former Name(s)				
Address	Street			
	City	State	Zip	
Telephone	Home:	Cell:	Work:	
General	Today's Date	DOB	Age	
	Number of years of education	Social Security #:		
Present Occupation	Employer Name	Occupation:		
Ethnicity:	Hispanic or Latino Non-Hispanic or Latino Decline			
Race:	American Indian Alaska Native Asian White Native Hawaiian Other Pacific Islander African American Decline			
Language	English Spanish Hmong Mandarin Other _____			

INSURANCE INFORMATION		
Source/Company:	**Group#:**	**Subscriber#:**

HEALTHCARE HISTORY		
Do you have a regular physician?	☐ Yes ☐ No	Name_____ Phone_____ Address_____ Do you want a summary sent to this person (as listed above)? ☐ Yes ☐ No
Were you referred here by someone?	☐ Yes ☐ No	Who sent you? _____ Address:_____ Do you want a summary sent to this person? ☐ Yes ☐ No
What are the major concerns or issues that bring you to Driftless?		
List any previous mental health therapy you have had.		

MEDICAL HISTORY

When did you last have a medical checkup?	Date
Have you ever had any of the following problems?	Seizure Yes No Head Injury Yes No High Blood Pressure Yes No Heart Trouble Yes No Kidney Problems Yes No Other: Diabetes Yes No Asthma Yes No Thyroid Problems Yes No Liver Problems Yes No High Cholesterol Yes No
Have you ever had any surgery or <u>medical</u> hospitalizations?	Date _____ List: _____ _____
Have you ever been hospitalized for <u>mental health</u> reasons?	Date _____ List: _____ _____ _____
Are you currently taking any prescription medication?	☐ Yes ☐ No <u>Name of Medication taken</u> <u>Dose</u> <u>How often</u> _____ _____ _____ _____ _____ _____ _____ _____
Are there other medications that you have used recently?	☐ Yes ☐ No If Yes, please list below:

Have you taken steroid or cortisone-type drugs within the last year? ☐ Yes ☐ No

Have you taken any over-the-counter meds, herbal remedies or supplements in the last month? Yes No

Please list below:

_____

Have you <u>ever</u> been on medications (other than those listed above) for depression, anxiety, or other psychological issues? ☐ Yes ☐ No

Please list: _____

_____

_____

If sexually active, do you use any contraceptives or protection from sexually transmitted diseases (STD's)? Please specify.

FAMILY HISTORY

Relationship status: ☐ N/A (Child) ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ In a significant relationship ☐ Separated from partner _____ Date _____			
If you are in a relationship, please complete:	Partner's Name:_____ How long in relationship: _____		
Please list all people with whom you currently live with.	Name(s)		
Please list parents, brothers and sisters who are not currently living in your home.	Name(s)	Age(s)	Relationship to person receiving services
Are you adopted?	☐ Yes ☐ No	Age(s)	Relationship to person receiving services
Please describe any family information (current/past) that might be helpful: • **Mental health issues** • **Medical issues** • **Deaths in family** • **Divorces, step-parents** **Any type of abuse/trauma**			
• **Are you currently religiously affiliated?**	☐ Yes ☐ No If Yes, what religion?__		
Former religious affiliation?	☐ Yes ☐ No If Yes, what religion? _____		

_____ _____

Signature of Person Completing Form and Relationship to client Date