NeuroPsychCPS
Trusted • Compassionate • Excellence

Neuropsychological and Clinical Psychotherapeutic Services, LLC

Intake Form

Please provide the following information and answer the questions below.
Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to you first session.

Name: ____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

____
(Last) (First) (Middle Initial)

Address: ____
(Street and Number)

____
(City) (State) (Zip)

Home Phone: (_______) ________________ **May we leave a voice message?** □ Yes □ No
May we leave a text message? □ Yes □ No

Cell / Other Phone: (_______) _________________ **May we leave a voice message?** □ Yes □ No
May we leave a text message? □ Yes □ No

Email: ____________________________________ **May we email you?** □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Safety Issues:
- □ None
- □ Suicidal Ideation
- □ Homicidal Ideation
- □ Other: ____

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Background Information

Identification

Birth Date: _______ / _______ / _______ Age**:** ___________________ **Gender:** ___________________

Ethnicity:

□ Asian Americans □Black and African Americans □ Hispanic or Latino origin
□ Middle Easterners and North Africans □ Native Americans and Alaskan Natives
□ Native Hawaiians and other Pacific Islanders □ White Americans □ Two or more races

Religion:

□ Buddhism □ Christianity □ Chinese tradition religion
□ Hinduism □ Islam □ Jewish
Nonreligions (Secular/Agnostic/Atheist) □ Primal-indigenous

Marital Status:

□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Please list any children / age: ____

Referred by: (if any): ____

History of Present Problem

1. **Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?**
   □ No
   □ Yes, previous therapist / practitioner: ____

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Please describe your current symptoms, onset, duration, frequency, etc.:

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Past Psychiatric History

Please describe any prior treatment, symptoms, diagnoses, hospitalization, suicide attempts, etc.:

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1. **Have you ever been prescribed psychiatric medication?**
   □ No
   □ Yes
   If yes, please list and provide dates: ____

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Trauma History

Please describe if you have experienced any trauma, when it occurred, persons involved etc.:

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Family Psychiatric History

Please describe any history of mental illness in the family, diagnoses, etc.:

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Medical Conditions & History

Please describe your current and past medical conditions, treatments, allergies, etc.:

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Current Medications

Please list any current medications, dosage, purpose, prescribing physician:

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Substance Use

1. **Do you drink alcohol more than once a week?**
   - ☐ No
   - ☐ Yes

2. **How often do you engage recreational drug use?**
   - ☐ Daily
   - ☐ Weekly
   - ☐ Monthly

Please describe any substances, state date, last use, amount, frequency, etc.:

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Family History

Please describe your family of origin, relationship with parents, siblings, significant other(s):

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In this 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 *(father, grandmother, uncle, etc.).*

	Please Circle	List Family Member(s)
Alcohol / Substance Abuse	Yes / No	
Anxiety	Yes / No	
Depression	Yes / No	
Domestic Violence	Yes / No	
Eating Disrobers	Yes / No	
Obesity	Yes / No	
Obsessive Compulsive Behavior	Yes / No	
Schizophrenia	Yes / No	
Suicide Attempts	Yes / No	

Social History

1. **Are you currently in a romantic relationship?**
   □ No
   □ Yes
   If yes, for how long? ____

   On a scale of 1-10, how would you rate your relationship? ______________________________

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2. **What significant life changes or stressful events have you experienced recently:**

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3. **Do you consider yourself to be spiritual or religious?**
   □ No
   □ Yes
   If yes, describe your faith or belief: ____

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Please describe any significant relationships, social support, nature / quality of relationships, etc.:

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Developmental History

Please describe any developmental milestones, delays, etc.:

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Educational / Occupational History

1. **Are you currently employed?**
   □ No
   □ Yes
   If yes, what is your current employment situation**:** ________________________________

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2. **Do you enjoy your work? Is there anything stressful about your current work**? ___________

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Please describe your level of education current, etc.:

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Legal History

Please describe any arrest history, sentencing, DUI occurrences, incarceration, litigation, etc.:

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General Health and Mental Health Information

1. **How would you rate your current physical health?** ***(please circle)***

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

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2. **How would you rate your current sleeping habits? *(please circle)***

   Poor Unsatisfactory Satisfactory Good Very Good

   Please list any specific sleep problems you are currently experiencing:

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3. **How many times per week do you generally exercise? ___________________________________**

   What types of exercise do you participate in: ____

   ____

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4. **Please list any difficulties you experience with your appetite or eating patterns:**

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5. **Are you currently experiencing overwhelming sadness, grief or depression?**
   □ No
   □ Yes
   If yes, for approximately how long? ____

6. **Are you currently experiencing anxiety, panic attacks or have any phobias?**
   □ No

□ Yes
If yes, please describe: ____

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7. **Are you currently experiencing any chronic pain?**
□ No
□ Yes

8. **What do you consider to be some of your strengths?** ___________________________________

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9. **What do you consider to be some of your weakness?** ___________________________________

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10. **What would you like to accomplish out of your time in therapy?** _________________________

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