M. VOGEL

BETTER INSIGHT. BETTER OUTLOOK.

New Patient Intake Form

If you are a returning patient, please fill in only the information that has changed.

A. Identification.

Your name: _____ Date of birth: _____ Age: _____

Nicknames or aliases: _____ Social Security Number: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ E-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

B. Referral.

How did you hear of my services? _____

Name (if referred from person): _____ Phone: _____

Address:

_____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No

How did this person explain how I might be of help to you? _____

_____

C. Religious and racial/ethnic identification.

Current religious denomination/affiliation ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu

Other (specify): _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, or meeting do you attend? _____

Ethnicity/national origin: _____ Race(s): _____

Other ways you identify yourself and consider important: _____

D. Your education and training.

Dates of Attendance	School	Accommodations	Graduation (GPA)

E. Employment and military experiences.

Dates of Employment/Service	Employer/Service branch	Job title or duties	Reason for leaving

F. Your medical care.

From whom or where do you receive your medical care? _____

Phone: _____ Address: _____

If you enter treatment with me for psychological concerns, may I tell your medical doctor so that she or he can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

G. Chief concern.

Please describe the main difficulty that has brought you to see me: _____

_____

_____

_____

Please check any of the following that apply:

❑ **Thoughts of harming self**

Explain: _____

❑ **Plans to harm self**

Explain: _____

❑ **Intentions to harm self**

Explain: _____

❑ **Attempts to harm self**

Explain: _____

❑ **Psychiatric hospitalizations**

Explain: _____

H. Treatment.

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

❑ No ❑ Yes If yes, please indicate:

When?	From whom?	For what?	With what results?

2. Have you ever taken medications for psychiatric or emotional symptoms? ❑ No ❑ Yes If yes, please indicate:

When? From whom? Which medications? For what? With what results?

I. Relationships in your family of origin.

Please describe the following:

1. Your parents' relationship with each other: _____

2. Your relationship with each parent and with any other adults present: _____

3. Your parents' medical problems, drug or alcohol use, and mental or emotional difficulties: _____

4. Your relationship with your sibling(s), in the past and present: _____

J. Abuse history.

❑ I was not abused in any way. ❑ I was abused.

If you were abused, please indicate the fol-lowing. For kind of abuse, use these letters: P = Physical, such as beatings.

S = Sexual, such as touching/molesting, fon-dling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect.

E = Emotional, such as humiliation, etc.

Age? Kind of abuse? By whom? Effects on you? Whom did you tell? Consequences of telling?

K. Present relationships (if applicable).

1. How do you get along with your present spouse or partner? _____

_____

_____

_____

2. How do you get along with your children? _____

_____

_____

_____

3. Your important friends, past and present:

Names	Good parts of relationship	Bad parts of relationship

L. Chemical use.

1. How many cups of regular coffee/tea do you drink each day? _____ How many cups of tea? _____ How many sodas/pop with caffeine (Coke, Pepsi, Mountain Dew, Dr. Pepper, Orange Crush, etc.)? _____ How many energy drinks? _____ How often do you use No Doz or similar caffeine pills? _____

2. How much tobacco do you smoke or chew each week? _____

3. Have you ever felt the need to cut down on your drinking? ❑ No ❑ Yes

4. Have you ever felt annoyed by criticism of your drinking? ❑ No ❑ Yes

5. Have you ever felt guilty about your drinking? ❑ No ❑ Yes

6. Have you ever taken a morning "eye-opener"? ❑ No ❑ Yes

7. How much beer,wine,or hard liquor do you consume each week,on the average? _____

8. Are there times when you drink to unconsciousness,or run out of money as a result of drinking? ❑ No ❑ Yes

9. Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? ❑ No ❑ Yes If yes, which and when?

_____

Which drugs (not medications prescribed for you) have you used in the last 10 years? _____

_____

_____

Please provide details about your use of these drugs or other chemicals,such as amounts,how often you used them, their effects,and so forth: _____

_____

M. Legal history.

1. Are you presently suing anyone or thinking of suing anyone? ❑ No ❑ Yes. If yes, please explain: _____

_____

_____

2. Is your reason for coming to see me related to an accident or injury? ❑ No ❑ Yes If yes, please explain: _____

_____

_____

3. Are you required by a court, the police, or a probation/parole officer to have this appointment? ❑ No ❑ Yes If yes, please explain:

_____

_____

4. Are there any other legal involvements I should know about? _____

_____

_____

N. Other.

Is there anything else that is important for me as your treatment provider to know about, and that you have not written about on any of these forms? If yes, please tell me about it below or on another sheet of paper: _____

_____

_____

O. Emergency information.

If some kind of emergency arises and we cannot reach you, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

Address: _____

P. Insurance information.

Please complete all that apply.

Primary Insurance Company:_____ Phone number:_____

Claims address:_____

Policy holder name as it appears on the card:_____

Policy holder date of birth:_____ Policy holder Social Security Number:_____

Policy holder relationship to patient:_____

Secondary Insurance Company:_____ Phone number:_____

Claims address:_____

Policy holder name as it appears on the card:_____

Policy holder date of birth:_____ Policy holder Social Security Number:_____

Policy holder relationship to patient:_____

If you are not submitting claims to your insurance company, then to whom should your bills be directed:

- ❑ Self
- ❑ Other: _____ _____ _____

(Name) (Address) (Phone)

Signature: _____ **Date:** _____

Printed Name: _____