

NEW PATIENT INTAKE FORM

Full Name: _____ Preferred Name: _____

Phone #: _____ Email: _____

Is it safe to contact you at the number above? _____

QUESTIONS

	Yes	No		Yes	No
Have you been in therapy before?	<input type="checkbox"/>	<input type="checkbox"/>	Are you committed to treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently on medication?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any medical problems?	<input type="checkbox"/>	<input type="checkbox"/>
If so, list here:			Do you experience hallucinations?	<input type="checkbox"/>	<input type="checkbox"/>
			Are you sexually active?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience suicidal thoughts?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have pets?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a known mental illness?	<input type="checkbox"/>	<input type="checkbox"/>	Have you been convicted of a crime?	<input type="checkbox"/>	<input type="checkbox"/>
If so, list here:			Are you in a relationship?	<input type="checkbox"/>	<input type="checkbox"/>
			Do you speak English fluently?	<input type="checkbox"/>	<input type="checkbox"/>

What are you hoping to achieve through therapy? _____

Do you have any concerns you would like me to know about? _____

I hereby certify that I have read this therapist's patient disclosure agreement as well as all other documents provided. I understand the contents of these documents and agree to the terms set forth therein.

Patient Signature: _____