

**Family Psychiatry & Psychology Associates, P.A.**  
**INTAKE FORM**  
**CONFIDENTIAL**

**Patient Information:**

**Date:** \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ M \_\_\_\_\_ F SSN: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Home: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name of Person(s) Financially Responsible: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Address (if different than patient's): \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Employer/School Information:**

Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Grade: \_\_\_\_\_

City/State: \_\_\_\_\_

Education/Degrees: \_\_\_\_\_

**Parent/Spouse's Information:**

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Emergency Contact Information:**

\*In Case of Emergency, Contact \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Home: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Who can we thank for referring you here today? \_\_\_\_\_ Internet \_\_\_\_\_ Phone Book \_\_\_\_\_ Friend  
\_\_\_\_\_ Doctor/Psychologist? (Name) \_\_\_\_\_ Other \_\_\_\_\_

# Medical History

**Patient Name:** \_\_\_\_\_

**Primary Care Physician:**

Name of Practice: \_\_\_\_\_ Doctor: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**Past Psychiatric and Medical Diagnoses (please give the year):**

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

**Current Medications (Include dosage and frequency):**

1) \_\_\_\_\_ 2) \_\_\_\_\_

3) \_\_\_\_\_ 4) \_\_\_\_\_

**Known Allergies:**

\_\_\_\_\_  
\_\_\_\_\_

**Severe Illness (childhood to present):** \_\_\_\_\_

\_\_\_\_\_

**Previous Out/Inpatient Therapy (please specify which):** \_\_\_\_\_

\_\_\_\_\_

**Stressors affecting you or your family in the past 1-2 years:**

|                                   |  |  |
|-----------------------------------|--|--|
| <input type="checkbox"/> Deaths   | <input type="checkbox"/> Job Change      | <input type="checkbox"/> Sexual Abuse        |
| <input type="checkbox"/> Births   | <input type="checkbox"/> School          | <input type="checkbox"/> Broken Relationship |
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Unwanted Pregnancy  |
| <input type="checkbox"/> Divorce  | <input type="checkbox"/> Separation      | <input type="checkbox"/> Substance Abuse     |
| <input type="checkbox"/> Moving   | <input type="checkbox"/> Physical Abuse  | <input type="checkbox"/> Medical             |
|                                   | <input type="checkbox"/> Other           |  |

**Presenting Problem/Reason for Visit:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_