PATIENT INFORMATION

Name:_____ Date of Birth: _____

Male ( ) Female ( ) Other ( )

SS#: _____ Marital Status: Married ( ) Single ( ) Other ( )

Address: _____
_____
_____

Phone #'s (Home): _____
(Cell): _____
(Work): _____

Email Address: _____

Preferred Pharmacy: _____
_____

Referred by: _____

Primary Care Physician: _____
_____

Employment Status: Employed ( ) Retired ( ) Other ( )

Employer Name & Phone #:
_____
_____

Emergency Contact(s)
Name & Phone #:
_____
_____
_____
_____
_____

Guarantor (Person responsible for payment):
Name: _____
Address: _____
_____
_____
Phone #: _____
SS#: _____ DOB: _____

I understand that I am officially responsible for all charges.

Signed: _____ Date: _____

Intake Form

To minimize time spent on the following in the appointment please fill this form out to the best of your ability:

Name: _____ DOB: _____ Age: _____

Race: _____ Martial Status: _____ Employment Status: _____

What is the best way to reach you and may leave a message? _____

May we call you to remind you of your appointment? _____

Who referred you to Dr Hines? _____
May we send him/her a copy of this evaluation? _____

What is the nature of your/their concerns? _____
_____
_____
_____

Are you on disability or currently seeking disability benefits? _____ If so, what condition are you on disability for? _____
_____

Who is your primary care physician? _____
May I send him/her a copy of your evaluation? _____

Who is your current psychotherapist or counselor? _____
May I send him/her a copy of your evaluation? _____

Psychiatric History

Have you had any prior trials of psychiatric medications, including antidepressants, stimulants, or antipsychotics? _____ If so, please list:

NAME OF DRUG	DOSE	HOW LONG TAKEN	RESPONSE

Have you ever been hospitalized for psychiatric reasons? _____ If so, please list when, where and why you were hospitalized:

_____
_____
_____

Do you have any history of suicide attempts? _____ If so, what was the means of your attempt? _____
_____

Do you have a history of violence? _____ If so, please describe: _____
_____
_____

Any legal charges pending? _____
Do you have access to guns? _____

Substance Abuse History

Have you received treatment for drug or alcohol treatment? _____ If so, please list when and where you received treatment: _____
_____
_____

Do you currently drink alcohol? _____
How many do you have per day/week/month? _____
Do you currently use illegal drugs or prescribed drugs in a manner not approved? ____
If so, please list the substances: _____
_____

Do you currently think you have an alcohol or drug problem? _____ If yes, why? ___
_____
_____

Medical History

Please list your current medical problems (hypertension, diabetes, etc.):

_____
_____
_____

(If more room is needed, please use the back of this form)

CURRENT MEDICATIONS DOSAGE INSTRUCTIONS FOR USE

_____
_____
_____
_____

Please list any herbal medications, vitamins of supplements used:

_____
_____
_____

Are you allergic to any medications? If so, what reactions do you have? *I.e. codeine=hives:*

_____
_____

Family Medical History

What illnesses run in your family and what is their relationship to you (ex. Grandfather-colon cancer)?

_____
_____
_____
_____

What psychiatric illnesses run in your family (addiction, bipolar disorder, depression, etc.) and how are they related to you?

_____
_____
_____
_____

Has anyone in your family (including extended family) committed suicide? _____
Has anyone in your family responded well to a specific psychiatric medication? _____
If so, which one?_____

Social History

Who is your employer? _____
How long have you worked there? _____
What is your profession? _____

Have you ever been married? _____ If so, how many times? _____
How long has your current marriage lasted? _____

Do you have children? _____ If so, how many and what are their ages? _____
_____
Do they live with you? _____

If you are currently in an exclusive relationship that is not marriage please list this and how long you've been involved? _____
_____

What is your highest level of education? _____
Where did, or do you attend school? _____
What is or was your major, if applicable? _____

Where did you grow up? _____
Are your parents still married or remarried? _____

How would you describe your childhood?
_____
_____
_____
_____

Do you consider yourself heterosexual, homosexual, or bisexual? (you may answer this in session, if you prefer.) _____

What activities do you enjoy doing?
_____
_____
_____

Do you exercise fairly regularly? _____

Review of Systems

Is there anything bothering you physically today? _____ If so, please list:
_____
_____
_____
_____

What is your goal for treatment?
_____
_____
_____