Comprehensive Intake Form

Full Name: _____

Date of Birth: _____

Gender:_____

Address: _____

Phone Number: _____

Email Address: _____

EMERGENCY CONTACT:

Name: _____

Relationship: _____

Phone Number: _____

REFERRAL SOURCE:

How did you hear about our services? _____

INSURANCE INFORMATION:

Insurance Provider: _____

Policy Number: _____

Group Number: _____

PRESENTING CONCERNS:

What brings you in today? _____

When did these issues begin? _____

Have you sought treatment for this issue before? _____

SUBSTANCE USE HISTORY
SUBSTANCES USED (CHECK ALL THAT APPLY):

□ Methamphetamines

□ Benzodiazepines

□ Prescription opioids

□ Heroin

□ Alcohol

□ Cannabis

□ Cocaine

□ Other: _____

Frequency of use: _____

Amount used per instance: _____

Age of first use: _____

Date of last use: _____

History of overdose (if any): _____

MENTAL HEALTH HISTORY:

Have you ever been diagnosed with a mental health disorder? □ Yes □ No

If yes, specify: _____

Current symptoms (check all that apply):

□ Depression

□ Anxiety

□ Suicidal thoughts

□ Homicidal thoughts

□ Hallucinations

□ Delusions

□ Other: _____

Current medications: _____

Previous MH treatment (e.g., therapy, hospitalization): _____

MEDICAL HISTORY:

Do you have any chronic medical conditions? □ Yes □ No

If yes, specify: _____

Current medications: _____

Allergies: _____

FAMILY HISTORY:

Family history of substance use disorder: □ Yes □ No

If yes, specify: _____

Family history of mental health disorders: □ Yes □ No

If yes, specify: _____

SOCIAL HISTORY:

Marital status: □ Single □ Married □ Divorced □ Widowed

Children: □ Yes □ No

If yes, specify ages: _____

Employment status: □ Employed □ Unemployed □ Student □ Retired

Education level: _____

Legal issues (if any): _____

SUPPORT SYSTEM:

Do you have a supportive network of friends or family? □ Yes □ No

Are you involved in any support groups or community activities? □ Yes □ No

If yes, specify: _____

GOALS FOR TREATMENT:

What are your primary goals for treatment? _____

ADDITIONAL INFORMATION:

Is there anything else you would like us to know? _____

Clinician Notes: