Felicia Einhorn, LCSW DCSW LLC

Therapy for individuals, Couples, Families & Groups

DEMOGRAPHIC INFORMATION

Referred By:	Date:
Name:	
Address:	City, State, Zip
Home Phone#:	Cell Phone#:
Date of Birth:	
Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single	Dates of Marriages:

Medical

Internist	Phone #:
Psychiatrist	Phone #:
Neurologist	Phone #:
Pain Management MD	Phone #:

PLEASE SEE MEDICATION RECORD PAGE FOR All OF THE MEDICATIONS/SUPPLIMENTS YOU ARE CURRENTLY TAKING

Emergency

Contact:	Relationship:
Home Phone:	Business Phone:
Cell Phone:	
Contact 2:	Relationship:
Home Phone:	Business Phone:
Cell Phone:	
Contact 3:	Relationship:
Home Phone:	Business Phone:
Cell Phone:	

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MEDICAL RECORD

NAME: _____

DATE	MEDICATION	DOSE GIVEN	FREQUENCY (i.e. 2X PER DAY)	TIME	AM/PM

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MENTAL HEALTH INTAKE FORM

PERSONAL INFORMATION

What is your major complaint?

When did this begin? Have you previously suffered from this complaint?

Previous therapist(s) seen for complaint:

Previous treatment for complaint:

Aggravating factors for complaint:

Relieving Factors:

CURRENT SYMPTOMS: (CHECK THAT APPLY)

☐ Anxiety	☐ Appetite Issues	☐ Avoidance	☐ Crying Spells	☐ Depression	☐ Excessive Energy
☐ Fatigue	☐ Guilt	☐ Hallucinations	☐ Impulsivity	☐ Irritability	☐ Libido Changes
☐ Panic Attacks	☐ Racing Thoughts	☐ Risky Activity	☐ Sleep Changes	☐ Suspiciousness	☐ Loss of Interest

Do you have thoughts of suicide?

Have you made any suicide attempts? If so when?

How?

Do you have thoughts of physically hurting anyone?

Who do you think about hurting?

How would you hurt them?

Have you ever physically hurt anyone?

MEDICAL HISTORY

Previous diagnosis/mental health treatment:

Previously treated by:

Previous medications:

Dates treated:

Describe any neglect you suffered(ing) and by whom?

Trauma suffered and by whom?

Abuse suffered

Have you ever served in the military? If yes, where?

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PRESENT SITUATION

Work: ☐ Full-Time ☐ Part-Time ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

☐ Married ☐ Single ☐ Widowed ☐ Divorced

Prior Marriages? If yes, how many?

How is your relationship with your partner?

Are you sexually active?

Do you have children? Dates of Birth:

How is your relationship with your child(ren)?

List anyone else who lives with you:

Are you a member of a religion/spiritual group?

What is your level of involvement?

Have you been arrested? When and why?

Have you ever tried any of the following? Check that apply.

☐ Alcohol ☐ Tobacco ☐ Marijuana ☐ Hallucinogens (LSD) ☐ Heroin ☐ Methamphetamines
☐ Cocaine ☐ Stimulants (Pills) ☐ Ecstacy ☐ Methadone ☐ Tranquilizers ☐ Pain Killers

If yes to any, list frequency/dates of use:

Have you ever abused prescription drugs? If yes, which ones?

Have you ever been treated for drug/alcohol abuse? If yes, when?

For which substances?

Do you smoke cigarettes? If yes, how many per day?

Do you drink caffeinated beverages? If yes, how many per day?

What would you like to get out of this therapy?

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF POLICIES AND PRIVACY PRACTICES

The undersigned acknowledges receipt of a copy of the currently effective Notice of Mental Health Practitioner's Policies and Privacy Practices. A copy of this signed and dated acknowledgement shall be as effective as the original.

Signature | Print Name | Date

If you are the legal representative of the patient, please print the patient's

Name | Authority

Thank you. If you have any questions about this form, or the attached notice please contact Felicia Einhorn LCSW.