The Barrington Center for Counseling and Psychotherapy

INTAKE HISTORY

Therapist: _____

Patient Information

Date: _____ Date of Birth: _____

Name: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Responsible Party Information *(if minor or dependent is involved)*

Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance Information *(please attach Insurance card to clipboard for verification)*

Insured's Name: _____

Relationship to Patient: _____

Employer's Name: _____

Occupation: _____

Insurance Company Name: _____

Insurance ID Number: _____ Group / Plan Number: _____

Insured's Social Security #: _____ Insurance Company Phone: _____

FOR OFFICE USE ONLY: **DX:** _____ **Session Fee:** _____

Additional Information

Emergency Contact: _____ Phone Number: _____

Relation to Patient: _____

School Name *(if minor)*: _____ Grade: _____

May we contact you at home? ◯ YES ◯ NO Cell? ◯ YES ◯ NO Work? ◯ YES ◯ NO

How were you referred to our practice? _____

General Information

The reason you have come to the Barrington Center (primary complaint):

People living in the household (names, ages and relation):

Marital Status: _____ Occupation: _____

Do you enjoy your work? ◯ YES ◯ NO

Educational level completed *(current students circle current / former students circle last)*

GRADE SCHOOL	HIGH SCHOOL	COLLEGE	GRADUATE SCHOOL *(or others)*

Are your parents living: Mother: ◯ YES ◯ NO Father: ◯ YES ◯ NO

If no, please specify cause of death and age: _____

Number of brothers: _____ Ages: _____

Number of sisters: _____ Ages: _____

Number of children: _____ Ages: _____

Medical Condition

Current Doctor: _____ Office / Hospital: _____

Current Medical Conditions *(main)*: How long have you had this condition?

_____ _____

_____ _____

_____ _____

Have you ever been hospitalized for depression or anxiety? ◯ YES ◯ NO

Name of Psychiatrist: _____

Current Medications

Name of Medication:	Dosages/Frequency	For what condition?

Leisure

What do you enjoy doing when you aren't working? How often? *(daily, weekly, other)*

_____

_____

Spiritual

Are you religious/spiritual? ◯ YES ◯ NO Do you meditate? ◯ YES ◯ NO

If yes, how do you express your religious/spiritual side? _____

_____

Social Support

Do you see yourself living in a supportive environment? *(Circle appropriate number)*

Not Well – 1 2 3 4 5 6 7 8 9 10 – Very Well

At this time, what is the stress level in your life?

No Stress – 1 2 3 4 5 6 7 8 9 10 – High Stress

Mental / Physical Information

Have you experienced: *(please check all that apply)*

- ☐ Lack of Motivation
- ☐ Irritability
- ☐ Chronic Worry
- ☐ Depressed Mood
- ☐ Decreased Energy
- ☐ Anxiousness
- ☐ Increase/Decrease in Eating
- ☐ Decrease in Social Relationships
- ☐ Decrease in Family Relations
- ☐ Suicidal Thoughts
- ☐ Other: _____
- ☐ Hyperactivity
- ☐ Worthlessness
- ☐ Sleep Disturbances
- ☐ Grief
- ☐ Hopelessness
- ☐ Panic Attacks
- ☐ Obsessions/Compulsions
- ☐ Attention/Concentration Problems
- ☐ Racing Thoughts
- ☐ Substance Use Past / Present *(alcohol, marijuana, cocaine, other)*

Health Habits *(please mark if answer is "yes")*:

Smoke ☐ Drink alcohol ☐ Eat a lot of sweets ☐

Do you exercise? ☐ Frequency and type: _____