Intake Form			
Name:		DOB/Age:	Race/Ethnicity:
Address:		Phone:	Gender:
Insurance Info	Policy Holder:	Accident claim # (if applicable):	
Primary	Secondary		
Referring physician:			
Main reason for coming in:			
Are there any current or pending legal issues/disability claims/accident claims/worker's compensation claims related to your presenting problem? Y/N If yes, please explain:			

CURRENT PROBLEMS		
Daily Functioning:		
Check any of the following daily activities that cannot be completed fully independently:		
Bathe	Use toilet	Get dressed
Prepare food/use stove	Walk in house/use stairs	Yard work
Home repairs	Grocery shop	Use telephone
Pay bills	Manage bank account	Take medicine
Be home alone	Drive a car	Other:

Cognitive Difficulties:		
Please check all of the following that currently give you difficulty:		
Mental processes slowed down	Trouble concentrating or easily distracted	Difficulty doing math in your head
Difficulty doing math in your head	Trouble thinking of words or the names of things you want to say	Trouble remembering what to buy when you go shopping
Forgetting peoples' names	Losing things	Forgetting recent events or experiences

Trouble recalling experiences or things you learned long ago	Getting lost or difficulty using maps	Trouble solving complex problems
Disorganized	Acting impulsively (without planning or anticipating consequence)	Other:

Did these cognitive problems come on gradually or suddenly?	
When did you first become aware of them?	
What do you think caused them?	
Since they started, have your symptoms worsened, improved, fluctuated, or stayed the same?	

Psychological, Emotional, and Interpersonal difficulties:		
Please check all of the following that you have recently or currently experience:		
Large or rapid fluctuations in mood	Anxious, fearful, nervous	Tense, high strung or have difficulty relaxing
Depressed mood	Tendency to be self critical or perfectionistic	Embarrassed by your limitations
Feel like a burden on others	Angry or have difficulty controlling temper	Have thoughts most people would consider to be strange or bizarre
Hallucinations (seeing, hearing, smelling or feeling things that weren't there)	Delusions (believing things that are very unlikely to be true)	Difficulty trusting others
Obsessive repetition of thoughts that bother you	Compulsive repetition of behaviors that are not really necessary	Serious conflict between family members
Marital problems	Sexual difficulties	Continuing to experience effects of prior physical, sexual or emotional abuse
Unusual behaviors at night	Other:	

Background Information:

Developmental/Education:	**Employment:**	**Social:**
Highest degree or last grade completed:	Occupation	Marital status:
Typical grades obtained/GPA:	Current employment status (or last date of employment):	# of children and ages:
Childhood history of: ☐ Special education ☐ Learning disabilities ☐ Repeating a grade ☐ Behavioral problems ☐ Social difficulties ☐ Developmental delays/early intervention ☐ Gifted/advanced placement	Current problems at work related to your presenting symptoms? If not working, do you participate in structured activities outside of the home?	Current living arrangements: Other people in household: Do you have friends that you see regularly?

Medical History:	
Diagnoses	Medications

*Can attach additional sheets as needed

Within the past year have there been any:		
Serious medical events/injuries/new diagnoses:	Medication changes:	Surgeries:

Mental Health Treatment:

Current or past treatment with a therapist, psychiatrist, or psychiatric hospitalization? Y/N
If yes, please describe when, duration of treatment, and if beneficial:

Substance Use:

- Current or past use of tobacco, alcohol, or other drugs? Y/N

If yes, please describe whether current use, which substances used, frequency and duration of use:

- Has your drug or alcohol use every been problematic and/or have you participated in a substance abuse treatment program? Y/N

If yes, please describe:

Family History:

	Current age/ age deceased:	Known or suspected dementia:	Psychiatric conditions: (specify)	ASD/LD/ ADHD:	Other medical/neuro conditions:
Mother:		☐	☐	☐	
Father:		☐	☐	☐	
Siblings:		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	
Children:			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
Maternal grandparents:		☐	☐	☐	
Paternal grandparents:		☐	☐	☐	
Extended Family:		☐	☐	☐	