STEPS
STRESS & TRAUMA EVALUATION AND PSYCHOLOGICAL SERVICES

NEW ADULT PATIENT INTAKE FORM

GENERAL INFORMATION

1.Name:_____2.Date of Birth:_____

3.Gender: _____3. Age:_____

4.Parent/Legal Guardian (if under 18): _____

5.Marital Status:

□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

6.Address: _____

7.Home Phone: __ _____ May we leave a message? □ Yes □ No

8.Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No

Email: _____

*Note: Email correspondence is not considered to be a confidential medium of communication, so we do not encourage communication via email. However, if you would like to be added to our mailing list and receive information about workshops and events, please indicate here:□ Yes □ No

9. Employment:

□ Student □ Employed full-time □ Employed part-time □ Unemployed

If employed, who is your employer?:_____

10. Emergency Contact:_____Phone #:_____

Address:_____

11. How did you hear about us?:_____

_____

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Clinician Initials:_____ Date:_____

MENTAL HEALTH HISTORY

12. Please describe briefly the problems you are experiencing:

_____

_____

_____

13. Have you received any type of mental health care in the past? □ Yes □ No

If yes, what type? /e.g. psychotherapy, medication, both/:_____

When/for how long?:_____

14. Are you currently seeing a mental health provider /e.g. psychologist, psychiatrist, social worker/?: □ Yes □ No

If yes, name:_____ Phone #:_____

15. Please list any relevant medications you are currently taking:

Medication Dosage Past Current

_____

_____

_____

_____

16. Do you use any of the following?: Yes/No Frequency (days per week):

Tobacco_____

Alcohol_____

Pain Killers_____

Marijuana_____

Other (please specify):_____

17. Have you/your child ever been hospitalized for psychiatric reasons? □ Yes □ No

If yes, please write down when, where, and reasons for hospitalization:

_____

_____

_____

_____

Clinician Initials:_____ Date:_____

FAMILY MENTAL HEALTH HISTORY

18. Below, please list if any family members have a history of mental health problems, such as depression, anxiety, posttraumatic stress, alcohol or substance use, OCD, eating disorders, schizophrenia, attempted/completed suicide attempts, or others:

Family member Issue

_____

_____

_____

_____

19. If you would like to be included in our email list and receive occasional updates on services we provide, health news, and other useful information, please provide us with your email below: (We promise not to email too frequently!)

_____

Clinician Initials:_____ Date:_____