BAY AREA HEALTH PSYCHOLOGY

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NEW PATIENT INTAKE QUESTIONNAIRE

The information you provide on this form is protected and confidential information. **Please fill out as much as you can**. If you would rather not answer a question, write in "need to discuss" (or NTD) so we can address it during your appointment.

Date: _____/_____/_____

Patient's Name: _____

Gender: ❑ Female ❑ Male Date of Birth: _____/_____/_____

Social Security Number: __ __ __-__ __-__ __ __ __

Primary Phone: __ __ __ - __ __ __ - __ __ __ __ ❑ Cell ❑ Home ❑ Work ❑ Parent's Phone
OK to leave voice messages? ❑ Yes ❑ No

Other Phone: __ __ __ - __ __ __ - __ __ __ __ ❑ Cell ❑ Home ❑ Work ❑ Parent's Phone
OK to leave voice messages? ❑ Yes ❑ No

Email Address: _____ OK to send messages? ❑ Yes ❑ No
*Please be aware that email is not a secure means of communication.

Preferred method of contact: ❑ Cell phone ❑ Home phone ❑ Email

Home Address: _____ _____ _____
Street City ZIP Code

Is it OK for us to send mail to you at your home address? ❑ Yes ❑ No

Mailing Address
(if different from home address) _____ _____ _____
Street City ZIP Code

Is it OK for us to send mail to you at this address? ❑ Yes ❑ No

Marital Status:
- ❑ Married
- ❑ Cohabitating
- ❑ Divorced
- ❑ Widowed
- ❑ Domestic Partnership
- ❑ Never Married Single
- ❑ Separated

Spouse or Partner's Name: _____

Gender: ❑ Female ❑ Male Date of Birth: _____/_____/_____

Ethnicity

Your ethnic background, race or religious or community affiliation: _____

Others Who Live in Your Household

Name: _____ Age: ____ Gender: ❑ F ❑ M Relationship to you: _____

Name: _____ Age: ____ Gender: ❑ F ❑ M Relationship to you: _____

Name: _____ Age: ____ Gender: ❑ F ❑ M Relationship to you: _____

Name: _____ Age: ____ Gender: ❑ F ❑ M Relationship to you: _____

Emergency Contact

Name: _____ Relationship to you: _____

Age: ____ Gender: ❑ F ❑ M Primary Phone: __ __ __ - __ __ __ - __ __ __ __

Medical Provider

Do you have a Primary Care Physician? ❑ Yes ❑ No

Name of Primary Care Physician:_____

Physician's Office Phone Number: __ __ __ - __ __ __ - __ __ __ __

City where physician's office is located: _____

Referral Source:

How did you learn of our services, or who referred you to our office? _____

_____

Education and Employment

Highest education completed:

- ❑ some high school
- ❑ high school diploma
- ❑ some college
- ❑ Associate's degree
- ❑ Bachelor's degree
- ❑ some graduate school
- ❑ masters level degree
- ❑ PhD, MD, JD or equivalent

Did you receive other trade, skill or work training? ❑ Yes ❑ No

If yes, describe: _____

What kind of grades did you typically get in school? ❑ High ❑ Passing ❑ Poor ❑ Failing

Were you ever diagnosed with or did you ever suspect you had a learning disability? ❑ Yes ❑ No

Current Employment Status:

- ❑ Full Time
- ❑ Part Time
- ❑ Self-employed
- ❑ Retired
- ❑ Consulting services
- ❑ Seasonal work
- ❑ Home-maker
- ❑ On Disability
- ❑ Unemployed
- ❑ Unemployed and stopped looking for work

If employed:

Employer: _____ City: _____

Position or Job title: _____

How long have you been with this employer? _____

What percent of your work time do you travel? _____

Community and Relationships

Do you belong to a religious community (church, synagogue): ❑ Yes ❑ No ❑ My spouse/partner does

Do you have someone to turn to when you need support or are feeling down? ❑ Yes ❑ No

Is there more than one person to whom you can turn when you need support? ❑ Yes ❑ No

Is there someone in your life who you feel understands you? ❑ Yes ❑ No

Is there someone in your life whom you trust to share your feelings? ❑ Yes ❑ No

Is there someone in your life whom you trust really cares about you? ❑ Yes ❑ No

How many years have you known your closest friend or friends? _____

Do you use social media (Facebook, Twitter, Linked-In, Geni, Ancestor) to keep in touch with friends and/or family? ❑ Yes ❑ No

Do you participate in virtual world games? ❑ Too Much ❑ A Lot ❑ In Moderation ❑ A Little ❑ No

INSURANCE INFORMATION

Do you have health insurance? ❑ Yes ❑ No

If you do not have health insurance, skip this page. If you do have insurance, please provide as much information as you can about your insurance coverage.

Name of Insurance Company: _____

Address: _____ _____
Department/street Department/suite

_____ _____ _____-_____
City State ZIP Code

Phone Number: (area code) _____ _____ _____ - _____ _____ _____ - _____ _____ _____ _____

Name of Policy Holder: _____

Policy Holder's Relationship to Patient: _____

Policy Holder's Social Sec. No.: __ __ __-__ __-__ __ __ __ Policy Holder's Date of Birth: _____

Policy Holder's Insurance ID (if different from Social Security Number): _____

Plan Number:_____ Group Number:_____

Policy Holder's Employer: _____

Do you have a secondary health insurance policy? ❑ Yes ❑ No

If you do not have secondary insurance, skip the remainder of this page.

Name of Secondary Insurance Company: _____

Address: _____ _____
Department/street Department/suite

_____ _____ _____-_____
City State ZIP Code

Phone Number: (area code) _____ _____ _____ - _____ _____ _____ - _____ _____ _____ _____

Name of Policy Holder: _____

Policy Holder's Relationship to Patient: _____

Policy Holder's Social Sec. No.: __ __ __-__ __-__ __ __ __ Policy Holder's Date of Birth: _____

Policy Holder's Insurance ID (if different from Social Security Number): _____

Plan Number:_____ Group Number:_____

Policy Holder's Employer: _____

Behavioral Health Treatment History

If this form is completed by someone other than the patient, "you" in all questions refers to the patient.

Are you currently receiving treatment from a psychiatrist? ❑ Yes ❑ No

If yes, name of provider: _____ Start Date: _____

Psychiatrist's phone number: _____ Fax number: _____

Focus of treatment?_____

Are you currently receiving treatment from any other psychologist or counselor? ❑ Yes ❑ No

Type: ❑ Psychologist ❑ Social Worker ❑ Marriage/Family Therapist ❑ Other _____

If yes, name of provider: _____ Start Date: _____

Provider's phone number: _____ Fax number: _____

Focus of treatment?_____

Have you received other treatment in the past year? ❑ Yes ❑ No

If yes, from what type of provider did you receive treatment:

❑ Psychiatrist ❑ Psychologist ❑ Social Worker ❑ Marriage Therapist ❑ Other Therapist
❑ Inpatient Facility ❑ Hospital-based Outpatient Program ❑ Drug/Alcohol Rehab Program
❑ Health Education Program ❑ Other Provider

Name of the provider, program, facility: _____

Focus of treatment? _____

Have you ever been hospitalized for psychiatric treatment? ❑ Yes ❑ No

If yes, during what year were you most recently hospitalized: _____

Are you currently taking any psychiatric medications? ❑ Yes ❑ No

If yes, please list what medications and approximate date of first use:

1. Medication: _____ Month/Year of first use: _____
2. Medication: _____ Month/Year of first use: _____
3. Medication: _____ Month/Year of first use: _____

Health Lifestyle Behaviors

Do you smoke? ❑ Yes ❑ No

If yes, how much? ❑ Less than 1 pack a week
❑ About 1 pack a day
❑ Two or 3 packs a day
❑ More than 3 packs a day

How many alcoholic beverages do you consume in a typical week? (1 drink = 5 ounces of wine or beer, or 1 ounce of hard alcohol)

❑ I don't drink at all
❑ Fewer than 3 a week
❑ Between four and six a week
❑ One or two a day
❑ More than two a day

Has anyone ever been annoyed with your alcohol intake? ❑ Yes ❑ No

Do you use any recreational drugs? ❑ Yes ❑ No

If yes, how often? ❑ A few times a year at special occasions or with friends
❑ About once a month
❑ About once a week
❑ More than once a week

If yes, what drugs to you use? _____

Do you exercise on a regular basis? ❑ Yes ❑ No

If yes, what activities to you do for exercise and how often? _____

_____

Do you have any concerns with your weight, body shape, nutrition, or your diet? ❑ Yes ❑ No

If yes, please describe: _____

Do you feel your use of the Internet, video games, mobile device (etc.) is excessive? ❑ Yes ❑ No

If yes, please explain: _____

Medical Background and History

How would rate your physical health at present? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Month and year of last doctor appointment: _____ Year of last physical exam: _____

Current Medical Conditions or Illnesses

Condition 1: _____ How long: _____

Condition 2: _____ How long: _____

Condition 3: _____ How long: _____

Condition 4: _____ How long: _____

Current Non-psychiatric Medications and which Medical Condition is it for

1. Medication: _____

Which condition (above) is this for: ❑ 1 ❑ 2 ❑ 3 ❑ 4

2. Medication: _____

Which condition (above) is this for: ❑ 1 ❑ 2 ❑ 3 ❑ 4

3. Medication: _____

Which condition (above) is this for: ❑ 1 ❑ 2 ❑ 3 ❑ 4

4. Medication: _____

Which condition (above) is this for: ❑ 1 ❑ 2 ❑ 3 ❑ 4

Sleep

Are experiencing problems with sleeping? ❑ No ❑ Sometimes ❑ Most of the time ❑ Always

If yes: ❑ Difficulty falling asleep ❑ Waking at night ❑ Not sleeping enough
❑ Sleeping too much ❑ Falling asleep during the day ❑ Erratic sleep schedule
❑ Night terrors, nightmares, bad dreams ❑ Sleep walking
❑ Other: describe:_____

Pain

Have you been experiencing pain? ❑ No ❑ Sometimes ❑ Most of the time ❑ Always

If yes, describe: _____

For how long, or when did it begin? _____

What treatment are you receiving? _____

Rate your average daily pain level (circle a number): Least 1 – 2 – 3 – 4 – 5 Most

Does the pain interfere with your sleep? ❑ No ❑ Sometimes ❑ Most of the time ❑ Always

Independent Living

Are you able to do all your daily activities on your own:

- ❑ Yes
- ❑ No, I need help with some activities
- ❑ No, there are some activities I can no longer do at all

If no, which activities are you no longer able to do on your own:

❑ Driving	❑ Mobility (walking)	❑ Climbing Stairs
❑ Feeding Myself	❑ Cooking	❑ Shopping
❑ House Cleaning	❑ Child Care	❑ Toileting
❑ Hygiene (bathing)	❑ Money Management	❑ Take Medications

Are you experiencing memory loss? ❑ No ❑ Sometimes ❑ Most of the time ❑ Always

Are you experiencing confusion? ❑ No ❑ Sometimes ❑ Most of the time ❑ Always

Are you experiencing loss of: ❑ Vision ❑ Hearing ❑ Speaking (remembering words) ❑ Balance

Do you need a hearing aid: ❑ Yes ❑ Sometimes ❑ No

If yes, do you have a hearing aid and do you wear it:

- ❑ Have one and wear it
- ❑ Have one but wear it only sometimes
- ❑ Have one but don't wear it
- ❑ Don't have one

Development History

Did you have any major illnesses or injuries while growing up? ❑ Yes ❑ No

If yes, describe: _____

Did you have any major medical procedures while growing up? ❑ Yes ❑ No

If yes, describe: _____

How many siblings do you have? _____

What number child were you? _____

How many years older than you is your next older sibling? _____

How many years younger than you is your next younger sibling? _____

Did you help raise any of your siblings? ❑ Yes ❑ No

Are your parents still alive?

Mother: ❑ Yes, age:___ ❑ No If "no", mother's age when she passed away: ___
Your age when she passed away: ___

Father: ❑ Yes, age:___ ❑ No If "no", father's age when he passed away: ___
Your age when he passed away: ___

Did your parents divorce while you were growing up? ❑ Yes, your age: ___ ❑ No

If "yes", did either of them re-marry before you were 18? ❑ Yes, mother ❑ Yes, father ❑ No

While growing up, were you mistreated by your parents or step-parents?
❑ No ❑ Yes, Mother ❑ Yes, Father ❑ Yes, Step-mother ❑ Yes, Step-father

While growing up, were you ever physical, sexually, or emotionally abused by anyone? ❑ Yes ❑ No

About how many times did you move before you were 18 years old? ____

Between ages 12 and 18, did you have friends and/or participate in organized youth activities (for example, church or temple group, school clubs or sports, scouts, political action)?

- ❑ No: I did not have any friends
- ❑ No: I did not have even one close friend
- ❑ No: I did not participate in youth groups
- ❑ I did not make friends easily
- ❑ Yes: I had several friends
- ❑ Yes: I had one or more close friends
- ❑ Yes: I participated in youth groups
- ❑ I made friends easily

Has anyone in your immediate family (parents, siblings) or extended family (grandparents, cousins, half-siblings) been diagnosed with or experience any of the following conditions? Or, do you suspect they might have any of these problems?

- ❑ Attention problems or ADD/ADHD
- ❑ Addictions (alcohol, drugs, gambling, sex)
- ❑ Bipolar disorder, manic depression
- ❑ Eating Disorder
- ❑ Developmental disorder, Autism, Asperger's
- ❑ Anxiety, fears, phobias, panic disorder
- ❑ Depression
- ❑ Schizophrenia or psychosis
- ❑ Suicidal thoughts or impulses
- ❑ Borderline Personality Disorder

<u>Use the space below to provide any notes or other information you would like to add</u>:

_____

_____

_____

_____

CLIENT'S RIGHTS AND RESPONSIBILITIES

As one of our clients, you have choices, rights, and responsibilities:

YOU HAVE THE RIGHT TO. . . .

1. Be treated with dignity and respect.
2. Maintain your privacy and confidentiality.
3. Receive explanations about any tests or procedures and any questions you may have.
5. Consent to or refuse any care or treatment.
6. Participate in making plans or decisions about your care during treatment.

YOU ALSO HAVE THE RESPONSIBILITY TO. . . .

1. Be honest about your history and lifestyle which may affect your physical and emotional health as well as the health of those around you.
2. Be sure you understand what you hear.
3. Practice making informed choices about whether to follow advice or instructions.
4. Respect the policies of our office.
5. Report any serious changes in your emotional status.
6. Keep appointments or cancel them at least 24 hours in advance.

It is our goal to help you in every way possible during treatment. Please let us know how we can best serve you by bringing your concerns to our attention.

Name of person who completed this form if other than patient: _____

Relationship to patient: _____

Patient's or authorized person's signature. Entering your full name here is the same as signing this form:

_____

Date: _____/_____/_____