CROSSROADS COUNSELING & CONSULTING ASSOCIATES, PC

Psychiatry, Mental Health and breakthrough TMS Treatment

CONFIDENTIAL INTAKE FORM

Date: _____

Personal Information

Name: _____ Age: _____ DOB: _____

Address: _____ Phone (home): _____

City, State, Zip: _____ Phone (cell): _____

Occupation: _____ Phone (work): _____

Employer: _____ Work Hours: _____ Education (years): _____

Emergency Contact & Telephone Number: _____

Primary Care Physician: _____ Phone Number: _____

Address: _____ City, Sate, Zip: _____

How did you find out about our services? _____

Current Problems

What problem brought you here? _____ When did it start? _____

List any stress that may have triggered this _____

*** Please complete symptom checklist on page 4 ***

Past Treatment History

Have you ever been treated for a mental, emotional or drug & alcohol problem? No Yes (If Yes please provide details below.)

Outpatient Treatment

When: _____ Provider: _____

Address: _____ City, State, Zip _____

When: _____ Provider: _____

Address: _____ City, State, Zip _____

Inpatient Treatment

When: _____ Provider: _____

Address: _____ City, State, Zip _____

When: _____ Provider: _____

Address: _____ City, State, Zip _____

Substance Abuse Treatment

When: _____ Provider: _____

Address: _____ City, State, Zip _____

☐ Detoxification ☐ AA/NA ☐ Partial Details: _____

☐ Outpatient ☐ Inpatient

Physical History

What medications are you currently taking? (Include over the counter, prescription and/or illegal drugs) _____

_____

Why are you taking these medications? _____

Allergies? _____

List current medical problems: _____

List any surgeries, serious illnesses and/or hospitalizations: _____

_____

What is the date of your last check up with your PCP? _____

What forms of exercise do you get and how often? _____

Hobbies _____

Have you had a recent weight change? Lost ☐ Gained ☐ How much: _____

Do you have good appetite? Yes ☐ No ☐ Do you eat healthy diet? _____

How much caffeine (coffee, tea, cola, chocolate) do you consume daily? _____

How much alcohols do you drink and what kind? _____

Do you use tobacco products? No ☐ Yes ☐ If Yes, what kind? _____

Marriage of Significant Relationships

Previous marriage/relationship:

Name of partner _____ Date begun _____ Date ended _____

Name of partner _____ Date begun _____ Date ended _____

Name of partner _____ Date begun _____ Date ended _____

Current marriage/relationship:

Name of partner _____ Date begun _____

How did you meet your current partner? _____

What were your expectations of marriage/relationship? _____

Specific complaints about your current marriage/relationship? (select and describe)

☐ Lack of communication _____

☐ Constant arguments _____

☐ Unfulfilled emotional needs _____

☐ Sexual dissatisfaction _____

☐ Financial disagreement _____

- ☐ In-law trouble _____
- ☐ Infidelity _____
- ☐ Domineering partner _____
- ☐ Suspicious partner _____
- ☐ Other _____

Please list your children:

Name	Age	Occupation	Residence

Family History
(Parents, Siblings, Grandparents, Aunts, Uncles)

Has any member of your family ever been treated for emotional, mental, drug/alcohol related problem? Yes ☐ No ☐

If Yes, who was treated and why? _____

Are any family members problem drinkers? _____

YOUR FATHER Living ☐ Deceased ☐

Current age _____ His age at the time of death _____

Education (years) _____ Cause of death _____

Occupation _____ Your age when he died _____

Describe his personality: _____

How are you similar to him? _____

YOUR MOTHER Living ☐ Deceased ☐

Current age _____ Her age at the time of death _____

Education (years) _____ Cause of death _____

Occupation _____ Your age when she died _____

Describe her personality: _____

How are you similar to her? _____

How did you get along with your parents? _____

How do (did) your parents get along with each other? _____

Were there any special problems, traumas, serious illnesses etc. in your family? No ☐ Yes ☐ (If Yes please provide details below.)

_____

Please list your brothers and sisters:

Name	Age	Occupation	Married/Children	Residence

SYMPTOMS

Instructions: Below is a list of problems and areas of life functioning in which some people experience difficulties. Using the scale below, WRITE IN THE COLUMN "RATING" THE NUMBER that best describes DEGREE OF DIFFICULTY YOU HAVE BEEN EXPERIENCING IN EACH AREA PRIOR TO THIS APPOINTMENT.

1 NO DIFFICULTY
2 A LITTLE
3 MODERATE
4 QUITE A BIT
5 EXTREME

Please respond to each item. Do not leave any blank. If there is an area that you consider to be inapplicable indicate it is NO DIFFICULTY ("0").

Example: To what extent are you experiencing difficulty in the area of FRIENDSHIPS? **2** **For 3 months**

TO WHAT EXTENT ARE YOU EXPERIENCING DIFFICULTY TN THE AREA OF:	RATING	HOW LONG?
1. MANAGING DAY-TO-DAY LIFE (e.g., getting places on time, handling money, making every day decisions)		
2. HOUSEHOLD RESPONSIBILITIES (e.g., shopping, cooking, laundry, keeping room clean, other chores)		
3. SCHOOL (e.g., academic performance, completing assignments, attendance)		
4. WORK (e.g., completing tasks, performance level, finding/keeping a job)		
5. ADJUSTING TO MAJOR LIFE STRESSES (e.g., separation, divorce, moving, new job, new school, a death)		
6. RELATIONSHIPS WITH FAMILY MEMBERS		
7. GETTING ALONG WITH PEOPLE OUTSIDE OF THE FAMILY		
8. ISOLATION OR FEELINGS OF LONELINESS		
9. LACK OF SELF-CONFIDENCE, FEELING BAD ABOUT YOURSELF		
10. APATHY, LACK OF INTEREST IN THINGS		
11. DEPRESSION, HOPELESSNESS		
12. SUICIDAL FEELINGS OR BEHAVIOR		
13. PHYSICAL SYMPTOMS(e.g., headaches, aches & pains, sleep disturbances, stomach aches, dizziness)		
14. FEAR, ANXIETY OR PANIC		
15. CONFUSION, CONCENTRATION, MEMORY		
16. MOOD SWINGS, UNSTABLE MOODS		
17. UNCONTROLLABLE, COMPULSIVE BEHAVIOR (e.g. eating disorder, hand-washing, hurting yourself) SPECIFY:		
18. DRINKING, TAKING ILLEGAL DRUGS, MISUSING DRUGS		
19. CONTROLLING TEMPER OUTBURSTS OF ANGER, VIOLENCE		
20. IMPULSIVE, ILLEGAL OR RECKLESS BEHAVIOR		

Please hold on to these papers until your therapist calls for you.

Thank you for choosing CROSSROADS COUNSELING & CONSULTING ASSOCIATES, PC
as your Psychiatry, Mental Health and breakthrough TMS Treatment provider!