HEALTHY BODY
healthy mind

INTAKE FORM

Please provide the following information and answer the questions below. Please note: Information you provide is protected as confidential information.

Name:_____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years): _____

Birth Date: _____ /_____ /_____ Age: _____ Gender: Male Female

Address:_____

_____

Home Phone: _____May we leave a message? Y/N

Cell/Other Phone: _____May we leave a message? Y/N

E-mail: _____ May we e-mail you? Y/N

*Please note: Email correspondence is not considered to be a confidential medium of communication. Will often not respond to emails for clinical questions or concerns. Please call the front office for scheduling appointments, refill requests, ect.

Preferred Pharmacy (NAME) and (NUMBER): _____

Emergency Contact Name/Number; _____

Physical and Mental Health Intake

Medical Problems/Conditions

_____

_____

_____

_____

Health Problems (**circle symptoms that bother you**)

Headache History of seizure Fatigue

Difficulty with Vision/Hearing/Smell Taste Trouble with Balance and or Walking

Dizziness Irregular Heart Beat Chest Pain Muscle Aches/Pains

Weight Gain or Weight Loss Change in Libido

Hair Loss, Excessive Hair Growth Cravings for Sugar/Sweets

Trouble Breathing Hot /Cold Body Temp Fragile Nails

Skin Rashes/Acne Menstrual Irregularities Constipation

Current Medication(**s**) **Supplement/Vitamins**

_____ _____

_____ _____

_____ _____

Allergies to Medication(**s**):_____

Family Health History:_____

Religious Affiliation:_____

Relationship Status: Please Circle.

Married Single Divorced Widowed In a long term relationship

Who lives at home with you? _____

Children and Ages _____

Education and Employment

Circle highest level of education

High School. Some College. College. Graduate Degree

Please circle you current employment status.

Full Time	**Homemaker**
Part Time	**Unemployed**
Self Employed	**Disabled**
Retired	**Looking for Employment**

Any learning disabilities or academic problems identified in childhood? _____

Use of any Legal or Illegal Substances in the Past? _____

Use of any Illegal or Legal Substance Currently? _____

Mental Health History

Past Psychiatric Problems or Diagnosis

_____ _____

_____ _____

PAST Psychiatric Medications. **Current Medications**

_____ _____

_____ _____

_____ _____

Please provide the date and reason for your most recent hospitalization. If not applicable, may simply write N/A.

_____

_____

Please provide the name and location of past psychiatrist or therapist.

_____

Current Symptoms; Please circle symptoms currently experienced.

Insomnia	Anxiety	Mood Swings
Depression	Impulsivity	Obsessive Thoughts
Sadness	Panic attacks	Sexual Difficulties
Anger	Change in Weight	Relationship Issues

Irritability	Problems with Focus	Trouble with work
Fear	Low Self-esteem.	Hormonal Imbalance

What are your goals from seeking treatment?

1. _____

2. _____

3. _____

Treatment Preference(s) Please check one or all of the following treatment methods you are most interested in exploring.

*Medication

*Supplements/Vitamins/Nutrient Therapy

*Laboratory Testing for: identification of hormonal Imbalances , nutrient deficiencies, metabolic disturbance (causes for weight gain/loss, side effects of commonly prescribed medications)

*Genetic testing for assistance in psychiatric medication selection

*Psychotherapy; individual or family. Education and support regarding the most effective ways of managing ones own psychiatric illness or of that of a family member/ partner.

WE ARE EXCITED TO MEET YOU AND DISCUSS YOUR PERSONAL QUESTIONS, CONCERNS, AND TREATMENT GOALS AT YOUR FIRST VISIT. WE LOOK FORWARD TO MEETING AND JOINING YOU ON YOUR JOURNEY TOWARDS A HEALTHIER MIND AND BODY!