**Vista Behavioral Health, LLC**
**152 Simsbury Road**
**Bldg 9, Fl 2**
**Avon, CT 06001**
**(860) 269-3101**

# NEW PATIENT INTAKE FORM

## DEMOGRAPHIC INFORMATION

Name: _____ Date: _____
Address: _____ H Phone: _____
City: _____ W Phone: _____
Zip: _____ Cell phone: _____
Date of Birth: _____ Age: _____ SS #: ___ / ___ / _____

Emergency contact: _____ Email: _____
Tel#: _____ Preferred contact method: _____
Exceptions on leaving message? _____

Referred by _____

Employer _____ Position _____ #Yrs _____
Education _____ Grade _____
Mar/Sep/Div/Single _____ Yrs Mar. _____ Times Mar. _____ Times Div. _____
Children/ Ages _____

## INSURANCE INFORMATION

Ins Carrier _____ Ins # _____ Plan _____
Subscriber _____ Subs DOB: _____ Relationship _____
Subscriber's Employer: _____ Effective as of: _____

## MEDICAL INFORMATION

Primary Care Phys.: _____
Last Physical : Last EKG:
Medication Allergies ( ) None
Current Medications _____

Medical History _____
(Illness/Injury _____
Hosp/Oper) _____

| | | | | |
|---|---|---|---|---|
| ☐ Hypertension | ☐ Head Trauma | ☐ G I Disease | ☐ Liver | ☐ ETOH Seizures |
| ☐ Epilepsy | ☐ Resp/Asthma | ☐ Cardiovasc | ☐ HIV / AIDS | ☐ Tremors |
| ☐ Thyroid Disease | ☐ Diabetes | ☐ Pancreatic | ☐ Blackouts | ☐ D.T.'s |

Please answer all questions: (**If answer is Yes please check )**

Are you currently experiencing ? ☐ No ☐ If Yes - Please check following:

( )Depression ( ) ADD / ADHD ( ) Obsessive thoughts or rituals

( ) Anxiety / Panic Attacks ( ) Temper problems ( ) Other _____

( ) Harmful or dangerous thoughts ( ) Sleep problems

Have you ever seen a ? ☐ No ☐ Yes - Name ? When ?

( ) Therapist / Counselor _____

( ) Psychiatrist _____

( ) EAP / Other _____

Have you ever taken ? ☐ No ☐ Yes - What ? When ?

( ) Antidepressants _____

_____

( ) Tranquilizers / Sleeping Pills _____

Have you ever been in a ? ☐ No ☐ Yes Where ? When?

( ) Psychiatric Hospital _____

( ) Substance Abuse Treatment Ctr. or Detox _____

( ) OutPt. Treatment /Partial Hospital Program _____

Have you ever been arrested or convicted of the following? ☐ No ☐ Yes

( ) DWI _____ ( ) Domestic violence _____

( ) Drug related _____ ( ) Other : _____

Is there a family history of any mental health problem in the following? ☐ No ☐ Yes

( ) Mother _____ ( ) Sibling _____ ( ) Grandparent _____

( ) Father _____ ( ) Child _____ ( ) Aunt or Uncle _____

Have you ever been abused? ☐ No ☐ Yes Notes

( ) Physically ( ) Emotionally _____

( ) Verbally ( ) Sexually (including rape) _____

List current medications/prior Med trials

_____

_____

_____

_____

Patient Name:_____

Date: _____