

INTAKE QUESTIONNAIRE

Name _____ Patient Account # _____
(Office Use Only)

List allergies and type of reaction: _____

List current medications and the condition for which they are prescribed: _____

List medications discontinued within the past month and the condition for which they were prescribed:

List hospitalizations, surgeries, illnesses, accidents and approximate dates: _____

List prior psychiatric treatment and approximate dates: _____

List treatment for drug and/or alcohol problems and approximate dates: _____

Explain in a few words the problem or symptom which brings you here: _____

With whom do you live? (Please include all in household members.) _____

Patient Signature* _____ Date _____

Legal Guardian Name** _____

Legal Guardian Signature** _____ Date _____

*If patient is **14 or older**, patient must sign all paperwork and add legal guardians to their HIPAA.

If patient is **13 or under, a legal guardian must sign all paperwork.

If you have any questions, please ask our staff.