PACIFIC BEHAVIORAL HEALTH CARE

INTAKE FORM

Please complete the following information:

NAME: _____ TODAY'S DATE: _____

ADDRESS: _____ CITY: _____ ZIP: _____

SOCIAL SECURITY NO._____ DATE OF BIRTH: _____ AGE: _____

TELEPHONE #S: HOME: _____CELL:_____ WORK: _____

E-MAIL: _____

OCCUPATION:_____ EMPLOYED BY: _____

MARITAL STATUS: MARRIED _____ YRS.____ SEPARATED____ SINGLE____ DIVORCED ____ WIDOWED _____

IF PATIENT IS MINOR, NAME OF RESPONSIBLE ADULT: _____

NAME OF CLOSEST RELATIVE : _____ PHONE: ( )_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HAVE YOU HAD PREVIOUS THERAPY? _____ YES _____ NO

IF YES, WITH WHOM?_____ LENGTH: _____

TYPE OF THERAPY: _____ INDIVIDUAL _____ FAMILY _____ COUPLES _____ GROUP _____ OTHER

PHYSICIAN'S NAME: _____ PSYCHIATRIST'S NAME: _____

DATE OF LAST PHYSICAL: _____ CURRENT PHYSICAL PROBLEMS: _____

CURRENT MEDICATIONS DOSAGES: _____

_____

MAY WE SAY WHO WE ARE IF WE PHONE YOUR HOME ? _____ YES _____ NO

HOW DID YOU HEAR ABOUT US? _____

_____

OFFICE USE

DX: _____

_____
_____
_____
_____