ANXIETY & OCD TREATMENT
— of Tampa Bay —

Intake Form

Patient name: _____

Date completed: ___/___/___ Patient age: _____ DOB: ___/___/___ Gender: _____

Address: _____
(Street Address) (City/State/Zip)

Best contact number: (_____)_____-_____ May I leave a voice message? Yes / No

Emergency contact name : _____ Relationship: _____ Phone: (_____)_____-_____

Who suggested that you come see me, or how did you find me? _____

If you found me online, please provide site: _____

What brings you to therapy? _____

_____

_____

Do you currently have any suicidal thoughts?	Yes	No
Have you ever attempted suicide?	Yes	No
Do you have any thoughts or urges to harm yourself?	Yes	No
Any history of self-harm?	Yes	No

What are your goals for treatment? What changes do you hope therapy will lead to? How long do you think these changes will take? _____

_____

_____

Previous psychological providers (therapists, psychiatrists, hospitals), and treatments for any emotional, psychiatric, or behavioral issues:

Therapist name and title	Type of treatment and purpose of therapy	Dates of treatment	Outcome/satisfaction/difficulties? Reasons you stopped?

Do you have a history of physical, sexual, emotional, or verbal abuse, or any significant trauma? _____

_____

_____

_____

List all health problems, including serious illnesses, hospitalizations, surgeries, head injuries, important accidents and injuries, eating patterns, exercise, sex, allergies, and other medical conditions: _____

_____

_____

_____

Have you been prescribed any psychiatric medication for emotional, psychiatric or behavioral issues?

Medication/Dosage	Reasons Taken	Physician (name)	Dates taken	Response to medication, side effects?

Is there a family history of any mental health, emotional, behavioral, or substance abuse issues?

Relationship	Paternal or Maternal Side	Issue/Diagnosis

Do you have any problems with falling asleep, staying asleep, or waking up? _____

_____

Any problems with appetite or significant (unexpected) recent changes in weight? _____

_____

Who else lives with you? (Provide names and relationship) _____

_____

How well do you get along with:

Spouse/significant other:	Excellent	Okay	Poorly	Not at all	N/A
Parents:	Excellent	Okay	Poorly	Not at all	N/A
Siblings:	Excellent	Okay	Poorly	Not at all	N/A
Coworkers:	Excellent	Okay	Poorly	Not at all	N/A
Friends/peers:	Excellent	Okay	Poorly	Not at all	N/A

Please list any concerns about your family or social relationships: _____

_____

_____

Compared to others, do you have: No friends Fewer friends Average number of friends More friends

List any interests, activities, or recreation that is important to you: _____

_____

Are you spiritual or religious? Does your spirituality, culture, or heritage influence you? How so? _____

_____

How much caffeine do you drink on a typical day? _____

Do you smoke? If so, how much?_____

Do you drink alcohol? How frequently and how much? _____

_____

Do you use any recreational drugs, prescription drugs not prescribed to you, or use prescription drugs at higher dosages than prescribed? _____

_____

_____

Are you currently involved in any legal matters? _____

_____

What is your current occupation? _____

How long have you had current job? _____

Are you applying (or planning to apply in the next 6-12 months) for disability? If so, why? _____

_____

Is there anything that is relevant or important, or that you feel I should know about? _____

_____

_____

_____

Signature

_____

Date