

Vanessa Underwood, PMHNP-BC

Client Intake Form

*ALL information is strictly confidential*

Name: Birth date: Gender: Today’s date:

Address: Age:

City: State: Zip: SSN:

Primary Phone: Home/Wk/Cell OK to leave confidential message? □Yes □No

Secondary Phone: Home/Wk/Cell OK to leave confidential message?□Yes □No

E-mail: Preferred contact method:

Employer’s Name/Address:

Highest grade or degree completed: Currently a student? □ Yes □ No

Partnership status: □Single □Married □Divorced □Separated □Partnered □Widow/er

Members of household: (include name, age & relationship to you)

Any children not living with you? (Names and ages)

MEDICATION MANAGEMENT HISTORY:

Please describe the reasons you are seeking medication management at this time:

Have you sought medications for this issue in the past? For other issues? (Describe where, when and from whom)

Please describe any recent changes in your life that may have caused stress such as moving, change in job, divorce, separation, other relationship changes or deaths:

MEDICAL HISTORY:

Name of current physician: Phone:

Have you ever had any major illnesses, surgeries, accidents or hospitalizations? □Yes □No

Describe:

Have you ever been hospitalized for psychiatric problems? When and for how long?

*- Please turn page over to complete next page -*

Are you currently taking any prescription or over the counter medications? □Yes □No

List medication/dosage/for what diagnosis:

Are you currently seeing a counselor? □Yes □No Counselor’s name & number:

Please indicate any of your biological relatives who have had psychiatric or emotional problems (name, relationship and problem or illness):

Please indicate how much alcohol (wine, beer, or hard liquor) you drink daily or weekly:

Please indicate any recreational drugs you may use and how frequently:

Please indicate how often you experience the following symptoms, emotions or sensations:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Never | Rarely(a few times a year) | Sometimes(a few times a month) | Frequently(a few times a week) | Almost Always(daily) |
| Anxious, nervous, worried, panicky |  |  |  |  |  |
| Angry, irritable, hostile |  |  |  |  |  |
| Confused thinking, memory problems |  |  |  |  |  |
| Compulsive (repeating thoughts/actions) |  |  |  |  |  |
| Difficulty concentrating/focusing |  |  |  |  |  |
| Depressed, low mood, sadness, crying |  |  |  |  |  |
| Eating problems, too much/not enough |  |  |  |  |  |
| Fatigue, low energy, tired |  |  |  |  |  |
| Grieving, mourning losses |  |  |  |  |  |
| Guilt, shame, remorse |  |  |  |  |  |
| Hallucinations |  |  |  |  |  |
| Impulsive, out of control, irresponsible |  |  |  |  |  |
| Inferiority, low self-esteem, worthless |  |  |  |  |  |
| Lonely, socially withdrawn, isolated |  |  |  |  |  |
| Lethargic, lazy, lack of motivation |  |  |  |  |  |
| Mood swings |  |  |  |  |  |
| Pessimistic, hopeless |  |  |  |  |  |
| Physical complaints, eg. Headaches |  |  |  |  |  |
| Procrastinate or can’t complete things |  |  |  |  |  |
| Self-neglect, poor self-care |  |  |  |  |  |
| Sexual issues, dysfunction, conflicts |  |  |  |  |  |
| Suspicious, trust issues |  |  |  |  |  |
| Temper problems, violent, threatening |  |  |  |  |  |
| Weight and diet concerns |  |  |  |  |  |
| Work problems, job-related issues |  |  |  |  |  |
| Women only: Menstrual irregularity |  |  |  |  |  |

Please feel free to add any other information you feel is important for me to know about you:

*I have completed this form truthfully to the best of my ability.*

*Client Printed Name Client Signature Date*