Bahn and Associates – 3000 Professional Drive Suite D, Springfield, IL. 62703

INTAKE FORM

Name _____ Gender _____ Date of Birth_____

Ethnicity_____ Language_____ Religion_____

Street address: _____

City _____ State _____ZIP _____

Home phone ( ) _____ Alt. phone ( ) _____

Referred by_____

Person to contact in an emergency _____ Phone ( ) _____

Address _____ Relationship to you _____

Persons with whom you live and their relationship to you:

_____

_____

Children: NO _____ YES____ (Please answer below)

Name Age

_____ _____

_____ _____

_____ _____

Occupation or work emphasis _____ Years of Education _____

Education major or training emphasis _____

Employer _____ Years worked there_____

Marital status (i.e. single, married, separated, divorced, living with partner) _____

Spouse/partner name _____ Spouse/partner occupation _____

Outpatient Medical Record - Please check all those that have occurred at any time.
Head injury____ Learning Problems ____ Alcoholism____ Substance Abuse____Hepatitis____ Chicken Pox____ Rheumatic Fever____Thyroid Problems____ Whooping Cough___ Hernia____Cancer/Tumor____ Poliomyelitis____ Sinus Problems____ Food Tolerance____ Speech Problems____ Epilepsy____ Bronchitis____ Measles____ Scarlet Fever____Typhoid Fever____ Hearing Problems____
Asthma____Mumps____Bulimia/Anorexia____ Tuberculoses____ Special Diets____ STD____ Appendicitis____ Hypertension____ Stroke____
Anemia____ Kidney Disease____ Diabetes____ Smallpox____ Tonsillitis____ Pregnancies____Heart Palpitations____ Pneumonia____
Neurological disease_____Other _____
Gastrointestinal problems: _____Significant weight loss/gain _____
Allergies (food, drug, other: please list)_____ HIV Positive? Yes ____ No ____ How Long? _____

Do you experience any of the following? Abdominal Pain_____ Changes in Appetite_____ Dizziness_____ Bed Wetting_____
Headaches_____ Fatigue_____ Frequent Urination_____ Fainting Spells_____ Chest Pain_____ BreathingProblems_____
Nausea_____ Colds_____ Nosebleeds_____Constipation_____ Sore throat_____ Coughs_____ Toothache_____ Menstrual Problems_____ Diarrhea_____ Vomiting_____ Ear Infection_____ Eye Vision Problems_____ Memory Problems _____

List any of the operations, Medical Procedures or Hospitalizations for medical, psychiatric/emotional, drug or alcohol problems. Please include Dates. _____

_____

_____

_____

Legal Status i.e. Are you currently involved with the criminal justice system? _____

	How long used?	How much used?
Alcohol	_____	_____
Tobacco	_____	_____
Nonprescription Drugs	_____	_____

Prescription drugs taken currently or in the past 6 months:

Prescription drug name	Frequency/Dosage	Reason Prescribed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Note any of the side effects of adverse reactions to medications listed above:

_____

Please help me understand what problems brought you to this office. Check all that apply: Marital___ Job___ Career_____ School___ Alcohol___ Substance Abuse___ Depression___ Moodiness__ Self Confidence___ Illness___ Fatigue___ Psychological___ Children___ Family___ Sexual Problems___ Traumatic Experience___ Loneliness___

Other or elaborate on above _____

Are you currently having any suicidal or homicidal ideation?_____

Previous Counseling or Psychotherapy? (please designate when, where, with whom and whether it was as a child, adult, couple or court ordered)

_____

Previous contact with psychiatrist for medication, or psychologist for psychological evaluation: YES ____ NO_____

_____

_____

Patient's signature **Date** **Name (printed)**