Bridging the Gap of America, Inc.

Intake Form

1. Patient Contact Information

Patient Name_____ Preferred Name _____
First MI Last

Address_____

Best contact phone number: _____ Email address: _____
Emergency Contact: _____ Tel: _____
Primary Care Physician: _____Tel: _____Fax:_____
Insurance Type: _____ Policy Number: _____
Policy Holder Name:

2. Date of Birth: _____/_____/_____ **3. Age:** _____

4a. How do you describe your race/ethnicity? _____ **4b. What is your gender?** _____

5. How do you describe your sexual orientation? _____

6. How do you describe your religious or spiritual beliefs? _____

7. Current marital status (Check one):
_ Single, never married _ Married, living together _ Separated _ Widowed _ Cohabiting with partner _Divorced
_ Married, not living together

On a scale from 1-10 how would you rate your current relationship? _____

8. Highest degree obtained: (Check only one)
_ High school graduate _ G.E.D. _ 4 year college degree _ M.B.A./M.A./M.S./M.P.H. _ M.D.
_ Junior college degree or technical school diploma _ J.D./LL.B. _ Ph.D _Other_____

9. What best describes your current employment status?

a. Employment Status

_ Unemployed, not looking for employment _ Unemployed, looking for employment _ Full-time employed
_ Part-time employed _ Retired _ Self-employed

10a. What is your occupation? _____

11. Current Residence
_ Own my house/ condo _ Retirement Complex/Senior Housing _ Renting _ Apartment /Condominium

12. Please briefly state the primary reason for your visit today, including Psychological Evaluations reasons:

_____

_____

13. Please rate the intensity of the pain related to your visit today?: _____
0 = No pain, 10 = Worst ever

14. Are you currently receiving mental health care? _ YES _ NO

(If yes) Name: _____ Contact Number: _____

15. Have you <u>ever</u> seen a psychiatrist/psychotherapist before? _ YES _ NO

Name: _____ Contact Number: _____

16. Previous mental history: Have you ever been treated for any of the following (check all that apply):

____ Depression
____ Anxiety
____ Panic Attacks
____ Anorexia/ Bulimia
____ ADHD
____ OCD
____ PTSD
____ Binge-eating
____ Bipolar (Manic / Depressive) Disorder
____ Schizophrenia
____ Personality Disorders
____ Alcohol Problems (including AA)
____ Substance Use
____ Suicidal or self-injurious behavior
____ Relationship difficulties
____ Problems coping with stress
____ Phobias
____ Other _____

17. On a scale of 1-10, how would you rate your current sleep habits?_____

18. On a scale of 1-10, how would you rate your current eating habits?_____

19. Have you ever been hospitalized for psychiatric reasons? _ YES _ NO
If yes, please provide details below:

20. Have you ever attempted to kill or harm yourself? _ YES _ NO _ More than 3 times

21. Please list all current medications below:

Name of Medication	Dosage	Prescribing Doctor	Phone Number	Pharmacy

22. Have you been prescribed psychiatric medication in the past? _ YES _ NO
If so please list:

23. Family History: Has anyone in your family ever been treated for any of the following? If yes, please indicate on the line provided which family member and, if applicable, whether on mother's side or father's side.

____ Depression _____

____ Anxiety _____
____ Panic Attack _____

____ Post-traumatic Stress _____

____ Bipolar/Manic Depression _____

____ Schizophrenia _____

____ Personality Disorders _____

____ Alcohol Problems _____

____ Substance Use _____

____ ADHD _____

____ Suicide Attempts _____

____ Psychiatric Hospital Stay _____

24. Medical History: Do you have, or have you ever had any of the following? Please check all that apply.

____ High Blood Pressure
____ Lung Disease
____ Diabetes
____ Heart Disease
____ Thyroid Disease
____ Anemia
____ Asthma
____ Skin Disease
____ Seizures
____ Gastrointestinal Problems (ulcers, pancreatitis, irritable bowel, colitis)
____ Arthritis or Rheumatoid Problems
____ Liver Damage or Hepatitis
____ Other Endocrine/Hormone Problems
____ Neurological Problems (stroke, brain tumor, nerve damage)
____ Gynecological / hysterectomy
____ Urinary Tract or Kidney Problems
____ Migraine or Cluster Headaches
____ Ear/Nose/Throat Problems
____ Viral Illness (herpes, Epstein-Barr, chronic hepatitis)
____ Cancer
____ Genital Problems

____ Eating Disorder
____ Eye Problems
____ Chronic pain
____ Fibromyalgia
____ HIV Positive or AIDS
____ Head Injury
____ High Cholesterol
____ Sleep apnea

Allergies: _____

25. Do you drink alcohol? _ YES _ NO

26. When was your last alcoholic drink? _____

27. How many drinks do you have on average each week?_____

28. Do you use tobacco? _ YES _ NO

29. Do you have any concerns for substance use or abuse currently? *Specify*:
_____

30. Do any of the following apply to you?

____ Problems with family or friends *Specify*: _____

____ Emotional problems *Specify*: _____

____ Occupational problems *Specify*: _____ _____

____ Housing problems *Specify*: _____

____ Economic problems *Specify*: _____

____ Problems with access to health care services *Specify*: _____

____ Problems related to interaction with the legal system/crime *Specify*: _____

____ Other psychosocial and environment problems *Specify*: _____

31. What outcome are you seeking by attending therapy at this time?

32. Is there anything else you would like your treatment provider to know about you or your reason for treatment?