FAX Completed form to Dr. Pastor at 609-710-7666

INTAKE FORM

Date: ____________________

Name: ____

Address: ____

City: ____________________________ State: _______ Zip: ___________________

Phone: ___________________________ Other phone: ______________________

Email: ____

Date of Birth: ___________________________ Gender: ___________________

Emergency Contact: ____

Referred by: ____

Your pharmacy:____

Name(s) and phone numbers of treating doctors & therapists:

____

Permission to contact above doctors & therapists? ________________________

Reason for seeking help at this time: ___________________________________

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Current Medications: ____

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Current medical problems: ____

Your goals for your mental health: ______________________________________

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Any history of the following (please answer Yes or No, and any explanation):

Thyroid problems:

Weight problems:

Describe sleep pattern in past month (circle):

No problem/mild or moderate insomnia/really bad insomnia/sleeping too much/nightmares

Head injury:

Seizures:

Suicide attempt:

Childhood trauma:

Hospitalization for mental health reasons:

Problems caused by alcohol use:

Estimate of number of alcoholic drinks per week:

Marijuana or other substances used, per week:

Really bad reactions to medication:

Family members with depression, anxiety, suicide attempt, addiction, or hospitalization:

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Single most important symptom or problem you'd like help with at this time:

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