NEW LEAF
PSYCHOTHERAPY SERVICES

Intake (Please complete all questions on this form clearly)

Date: _____

Clients Legal Name: _____
Address: _____

_____
Phone (Home): _____ Phone (Work): _____
Cell: _____
Date of Birth: _____
Gender: _____ Email address:

_____

Insurance Information:
Primary Card Holders Legal Name:
Employer: _____Occupation:

_____
Date of Birth: _____
Insurance Company _____
Member ID# _____ Group # _____

Please Inform your Primary insurance of your secondary

Secondary Card Holders Legal Name: _____
Employer: _____Occupation: _____
Date of Birth: _____
Insurance Company _____
Member ID# _____ Group # _____

Please Inform secondary insurance of your primary coverage

(Please attach a copy of the front and back of the Insurance Card)

Advance Directives:
I have an Advanced Directive/Instruction for Mental Health Treatment. ☐ Yes ☐ No

Emergency Information:
Name of Emergency Contact: _____ Phone: _____
Relationship to Patient: _____
(By filling this section out it allows us to call this person in an emergency)

Lakeside Office Park, Suite 504, Southampton, PA 18966 or
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Precipitating Event (why treatment now?**):**

_____

_____

_____

Suicide Risk Assessment:

Have you ever had feelings or thoughts that you did not want to live? ☐ Yes ☐ No
If YES, please answer the following. If NO, please skip to the next section.
Do you currently feel that you do not want to live? ☐ Yes ☐ No
How often do you have these thoughts?

_____

Has anything happened recently to make you feel this way?

_____

Do you feel hopeless and/or worthless?

_____

Have you ever tried to harm yourself before?

_____

Homicidal Ideation Assessment:

Do you currently have thoughts of hurting/someone else? ☐ Yes ☐ No
If YES, who:_____
Do you have a plan? ☐ Yes ☐ No
What is it? _____

Previous Medical History:

Allergies (adverse reactions to medications/food/etc.): _____
Primary Care Physician: _____
Telephone Number: _____ Fax Number: _____
Date of Last Physical Exam: _____
Findings from Exam: _____
Any relevant medical conditions (diabetes, hypertension, head traumas, cardiac problems, asthma or other breathing problems, cancer, etc.):

_____

_____

Current medications (Include prescribed dosages, dates of initial prescription and refills, and name of doctor prescribing medication):

_____

Hospitalizations/Surgeries (include dates, complications, adverse reactions to anesthesia, outcomes, etc.):

_____

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Past Psychiatric History:

Outpatient treatment ☐ Yes ☐ No If yes, please describe when, by whom, and nature of treatment.
Reason Date Treated by Whom

_____

_____

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where.
Reason Date Hospitalized Where

_____

_____

Results of recent laboratory tests and consultation reports:

_____

_____

The following information is option to fill out. However, it will be reviewed with your therapist during the first session.

Relationship History and Current Family:

Are you currently: ☐ Married ☐ Partnered ☐ Divorced ☐ Single ☐ Widowed
How long? _____
If not married, are you currently in a relationship? ☐ Yes ☐ No If yes, how long?

_____
What is your spouse or significant other's occupation?
_____ Describe your relationship with your spouse or significant other:

_____
Have you had any prior marriages? ☐ Yes ☐ No. If so, how many? _____
How long? _____
Do you have children? ☐ Yes ☐ No If yes, list ages and gender:

_____

_____
____ Describe your relationship with your children:

_____
List everyone who currently lives with you:

_____
Are you sexually active? ☐ Yes ☐ No
How would you identify your sexual orientation? _____
☐ Unsure ☐ Prefer not to answer

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Source of Information being provided to therapist: _____

Current Symptoms Checklist:

☐ Depressed mood	☐ Unable to enjoy activities	☐ Sleep pattern disturbance
☐ Loss of interest	☐ Concentration/forgetfulness	☐ Change in appetite
☐ Excessive guilt	☐ Fatigue	☐ Decreased libido
☐ Racing thoughts	☐ Impulsivity	☐ Increase risky behavior
☐ Increased libido	☐ Decrease need for sleep	☐ Crying spells
☐ Excessive energy	☐ Increased irritability	☐ Avoidance
☐ Excessive worry	☐ Anxiety attacks	☐ Suspiciousness

☐ Visual Hallucinations_____ ☐ Audio Hallucinations _____ How many hours of sleep?:_____

☐ Self-Injurious Behaviors

Describe:

_____

Additional Information:

_____

_____

_____

Substance Abuse History (***complete for all patients age 12 and over***)

Any current or previous substance issues?

Have you ever been treated for alcohol or drug use or abuse? ☐ Yes ☐ No

If yes, where were you treated and when

_____

Trauma History (Elaborate if you feel Comfortable):

Do you have a history of being abused emotionally, sexually, physically or by neglect? ☐ Yes ☐ No.

_____

_____

_____

Psychosocial Information:

Educational History:

Highest Grade Completed? _____ Where?

_____

Did you attend college? _____ Where? _____ Major?

_____

What is your highest educational level or degree attained?

_____

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Occupational History:
Are you currently: ☐ Working ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired
How long in present position? _____
What is/was your occupation? _____
Where do you work? _____
Have you ever served in the military? _____ If so, what branch and when?
_____
Legal History:
Have you ever been arrested? _____
Do you have any pending legal problems? _____
Spiritual Life:
Do you belong to a particular religion or spiritual group? ☐ Yes ☐ No
If yes, what is the level of your involvement? _____

Support System:
_____
_
Were you adopted? ☐ Yes ☐ No Where did you grow up?
_____
List your siblings and their ages:
_____
_____

Did your parents' divorce? ☐ Yes ☐ No If so, how old were you when they divorced?
_____
If your parents divorced, who did you live with?
_____

Children and Adolescents *ONLY*:

If parents are divorced (Please attached a copy of the Custody Agreement) :
Legal Custody: _____ Physical: _____
Shared: _____
Developmental History (developmental milestones met early, late, normal)**:**
_____
_____

Perinatal History (details of labor/delivery)**:**
_____

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