PATIENT INTAKE

PART ONE: PATIENT IDENTIFYING INFORMATION

last | first | nickname(s)

birth month | day | year

☐ male ☐ female ☐ other

home telephone | mobile telephone

email

Calls will be discreet, but please indicate any restrictions and/or preferences:

____

____

MARITAL STATUS:

☐ single/never married ☐ divorced/separated ☐ partnered/married ☐ widowed

EMERGENCY CONTACT:

____

name

____

relationship (i.e., friend, relative, physician, etc.)

______________________ ______________________

home phone mobile

PART TWO: PSYCHIATRIC HISTORY

Are you/your child in treatment with another mental heath professional?

☐ yes ☐ no

name

Have you/your child ever had psychological treatment?

☐ yes ☐ no

With whom?

What is your current diagnosis?

What medications are you currently taking?

Who is your current psychiatrist?

name

phone

fax

CHILD PATIENTS ONLY

Parent/Guardian Information:

name

age

education level

home phone

mobile phone

email

Parent/Guardian Information:

name

age

education level

home phone

mobile phone

email

Child's School: ______________________

Grade: ______________________

Special Education Plan:

☐ Yes ☐ No

PART THREE: REFERRAL

How did you hear about us?

☐ friend ☐ family member ☐ CCBTC website ☐ healthcare provider ☐ other (please specify) ____________

If you were referred by a healthcare provider please tell us their name, place of business and relationship to you: