HOW WELL DO YOU KNOW YOUR PATIENT?

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Paralegal
how well do you know your patient?

Introduction

There are certain professions where it is critical for the provider of services to obtain as much information as is reasonably appropriate at the start of the relationship with a prospective client or patient. Marriage and family therapists are an example of such a profession.

The patient intake process is mutually beneficial for both the therapist and the patient. For example, the patient intake process is the first opportunity you create for your patient(s) to identify—or to even reflect and contemplate on—the reasons they decided to embark on a therapeutic journey. Also, it provides you the opportunity to obtain information that may be relevant to the root cause or causes that underlie a patient’s presenting issue(s). For example, the responses provided within the patient intake can help you discern whether or not the patient’s issues are within your scope of practice and/or competence to treat, and if so, what modalities may be most helpful. Understanding a patient’s employment situation may indicate whether or not the patient qualifies for a sliding-fee. Even a vague, illusive, or non-responsive answer can be the starting point for a therapeutic dialogue and provide a window into what issues may arise in the future.

Hence, a comprehensive patient intake process, whether in writing, verbally, or both, can be the first collaborative step that the therapist and the patient take to facilitate the path to healing, wholeness, and well-being. This article, in addition to providing a sample Patient Intake Form, discusses some of the considerations to be mindful of with respect to information that is shared or communicated to the patient through the patient intake process.

Therapeutic and Clinical Considerations

In consulting with clinicians about some of the therapeutic and clinical considerations that could arise as part of the patient intake process, it was articulated that having a comprehensive intake questionnaire could potentially be off-putting or create an unduly burdensome experience for the patient. As one clinician poignantly observed, “Some of the information, especially personal information, which may be among the reasons for seeking therapy, may be too sensitive for the client to feel comfortable revealing on an intake form. A long comprehensive form in itself may be so off-putting, as to cause someone to not seek out therapy.” 1 Another clinician recognized that a patient intake questionnaire should allow “the client to be able to tell the story in his/her own terms.” And that, a lengthy and detailed form could “be emotionally difficult for [the patient] to fill out, especially if he/she has not even met the therapist.” 2

Hence, while it is important for a clinician to gather clinically relevant information, it is paramount that the therapist remain sensitive as to how the patient experiences the intake process.

Contacting a Patient’s Previous or Current Mental or Medical Health Care Providers

Sometimes to provide the best possible care, it may be necessary for a therapist to consult with a patient’s previous or current health care providers. Both state and federal law allow for permitted exceptions to confidentiality that permit licensed health care providers to exchange and discuss information about a patient without the patient’s written authorization as long as it is for the purpose or diagnosis of treatment.3

A patient may indicate during the patient intake process, or any time after, that he or she does or does not want you to contact a current or former provider. However, the law recognizes that clinicians may have a legitimate need to communicate with one another about the care of a mutual patient regardless of whether the patient consents. As explained above, the law provides exceptions to allow for these types of communications.

Avoiding Duplication of Services

During the patient intake, it may be valuable to inquire whether or not the patient is currently receiving therapeutic services from another psychotherapist and to ensure there is not a duplication of services. CAMFT Ethical Standard 3.10 states the following:

PATIENT SEEING TWO THERAPISTS: Marriage and family therapists do not generally provide professional services to a person receiving treatment or therapy from another psychotherapist, except by agreement with such other psychotherapist or after termination of the patient’s relationship with the other psychotherapist.

Thus, marriage and family therapists are encouraged to coordinate care with a patient’s other psychotherapist.
No matter how much information you gather about your patient during the intake process, the course of treatment is obviously not a forgone conclusion. The knowledge you have of your patient, and the information you gather from your patient, will expand as the bonds of trust between you and your patient grow over time.

Third-Party Payers
It is legal and ethical for providers to accept payment from a third party. Payment by a third-party does not entitle the third party payer to a patient’s confidential information. However, as explained in the CAMFT Code of Ethics, marriage and family therapists, “represent facts regarding services rendered and payment for services fully and truthfully to third-party payers and others.” Hence, if a patient’s therapy is paid for by a third-party, the therapist may want to establish at the outset, if and when information regarding the patient’s treatment will be shared with a third-party payer. If the third-party payer is an insurance company with whom the therapist is contracted, the therapist may consider discussing how and when confidential patient information may be released to the insurance company.

Sliding Fee Scale
Under California licensing regulations, it is a form of unprofessional conduct to fail to disclose to the patient the fee to be charged for the professional services or the basis upon which the fee will be computed. This includes sliding fee schedules offered by a therapist to patients who face a variety of financial circumstances, such as, being on a fixed income, being unemployed, or having limited resources due to extenuating circumstances.

Scope of Competence
Understanding at the outset what a patient’s presenting issues are can help a provider discern whether or not the patients issue are within the provider’s scope of competence to treat based on the provider’s specializations or areas of expertise obtained through training, education and experience. Evaluating how your competencies may be able to serve or benefit the patient will help you determine whether or not a higher level of care of different type of care should be recommended.

Sample Patient Intake
Following this article is a sample patient intake questionnaire/form that incorporates a myriad of subject matters and areas. It is by no means intended or suggested that this sample serve as the model or template that you use for your patient intake form; or, that you adopt this sample to serve as your patient intake questionnaire.

The sample is meant to provide you with ideas about how to make your patient intake as inclusive, informative and insightful as possible given the client population you serve. Therefore, some sections, questions, and response categories may be more relevant and useful than others depending on the setting in which you work, your specializations, and your clientele.

Final Words
No matter how much information you gather about your patient during the intake process, the course of treatment is obviously not a forgone conclusion. The knowledge you have of your patient, and the information you gather from your patient, will expand as the bonds of trust between you and your patient grow over time. It is your decision as a practitioner to decide what questions will be the most useful in establishing trust and rapport at the outset of treatment. The patient intake process is a good place to start.

Clearly, there is no limit as to what you can include to be part of your patient intake. The intake can be insightful and provoking for both you and your patient. Evasive responses could be the reason for in-depth discussions. Very detailed responses may help you determine whether it is more appropriate to make a referral to a different type of provider or help you discern the modality that can be the most helpful for your patient.

So, how well do you know your patient?

Acknowledgment: I’d like to thank Ronald Mah, LMFT and Jane Kingston, LMFT for offering such valuable insights and information and for making this article possible.

Endnotes
1 Ronald Mah, LMFT
2 Jane Kingston, LMFT
3 California Civil Code, Section 56.10(c) and 45 C.F.R. Section164.502
4 CAMFT Code of Ethics, Section 9.5.
5 California Business and Professions Code, Section 4982(n)

This article is not intended to serve as legal advice and is offered for educational purposes only. The information provided should not be used as a substitute for independent legal advice and it is not intended to address every situation that could potentially arise. Please be aware that laws, regulations and technical standards change over time. As a result, it is important to verify and update any reference or information that is provided in this article.

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SAMPLE Patient Intake Questionnaire

Note: This is a sample intake questionnaire which includes a wide variety of potential questions that can be asked of new clients during the intake process. Providers are encouraged to modify the content and format in accordance with their own individual preferences and practices.

General:
Name (Last, Middle Initial, First): ________________________________ Date: ________________________________
Street Address: ________________________________ City: ________________________________ State: ________
Home phone: ________________________________ Alternate phone: ________________________________
E-mail: ________________________________ Alternate E-mail: ________________________________
Please indicate the means by which you prefer to be contacted. You may check more than one:
Phone: ____ Text: ____ E-mail: ____ Regular Mail: _____. If you would prefer to be contacted at a phone number, e-mail, or address other than what is listed above, please provide that information here:
________________________________________________________________________________________
Date of Birth: ___________ Age: ________________________________

Gender:
Woman: ____ Man: ____ Transgender: ____ Transman: ____ Transwoman: ____
Gender Nonconforming: ____ Other: ________________________________

Orientation:
Queer: ____ Questioning: ____ Other: ________________________________
Prefer not to answer: ____

What type of services are you currently seeking? Please mark an “X” by the type of services you are seeking.

Individual therapy
Marital/Couples therapy
Family therapy
Group Therapy
Other (describe)
Unsure

Goals of Treatment:
What compelled you to seek therapy at this time?
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Describe your current concerns, issues, or problems that you hope to resolve:
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________

What do you hope to gain from therapy?
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________

**Relationship Status (Please check all that apply):**

Are you presently married or involved in a relationship? Yes____ No_____
If you answered yes, how would you describe your current level of satisfaction with the relationship?
__________________________________________________________________________________________

Have you married previously? If yes, when? _________________________________
Name of the individual whom you identify as your significant other: ________________________________

If you are married, or in a relationship, rate your level of contentment/happiness/satisfaction in the relationship on a scale of 1 to 10 (Number 1 indicates a sense of being very or extremely happy and the number 10 indicates a sense of being extremely unhappy). Briefly explain the rating you give in the space provided:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

On a scale of 1 to 10, describe your level of commitment to your relationship (Number 1 indicates a sense of being very committed and the number 10 indicates a sense of not feeling at all committed). Briefly explain the rating you give in the space provided:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

**Source of Income:**
Employment: _____ Unemployment: _____ Spouse/Significant Other: _____
Social Security: _____ Short Term-Disability: _________________________________
Other: _________________________________
how well do you know your patient?

Current Employment Status (Please check all that apply):
On medical leave: __________ Unemployed and looking for work: _____
Not employed due to other reasons ___ Full-Time Student: ____________
Part-Time Student: ____________________

Education Information: (Please check the highest level of education/degree you have received):
Elementary, Grades 1-8: _____ Some High School (no diploma): _____
High School Diploma/GED: _____ Some College (no degree): _____
Technical/Trade School Graduate: _____ Associate’s Degree: ____ Bachelor’s Degree: ____
Master’s Degree: ______ Professional Graduate Degree (i.e., MD, JD, etc.): ______
Doctoral Degree (i.e., PhD, EdD, etc.): ______

Military History:
Currently on active duty: __________ Served in Military (please circle length of time served) for:
______ number of weeks, months, or years. Never served in the military: __________
If you have served in the military were you ever deployed, yes or no? Yes: _____ No: ____.
If yes, please describe your deployment experience and any incidence or issues that arose for you during or after your deployment:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Legal History:
Have you been ordered by the court to participate in this therapy, yes or no?
Yes: _____ No: ____ If yes, you may be required to supply supporting documentation such as a copy of the court order.

Are you currently involved in any kind of litigation or legal dispute, yes or no?
Yes: _____ No: ____ If yes, please explain (i.e., custody dispute, dissolution proceedings, etc.):
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Emergency Contact Information: (Who you prefer me to contact in case of an emergency)
Name: ___________________________ Relationship: ____________________________
Phone number: ___________________ Email: ________________________________

Referral Information:
Were you referred? Yes: _____ No: _____ If referred, by whom?
Payment Information:
Please indicate how you intend to pay for treatment:
Cash: ___ Check: ___ Credit Card: ___ Employee Assistance Program: ___ Insurance: _____
Third-Party: ______. If a third-party will be paying for your treatment please provide the
following information: Name of the person paying for your therapy: _______________________
Your Relationship to this person: _______________________________________________________
Contact Information for this person: ____________________________________________________

If you are planning to use health insurance, please provide the following information:
Name of Insurance Company: ____________________________
Subscriber’s Name: ____________________________________
Insured’s ID number: __________________ Group Policy Number: ______
Co-Payment Amount: ______________
Insurance Claim’s Mailing Address: ____________________________
Telephone number: ______________________________________

Previous Mental Health Treatment History:
Have you participated in therapy? Yes: _____ No: ____ If YES, please complete the information
below:

Name: ______________________________ Type of Provider (Psychiatrist, Psychologist, Therapist, or
Other): ______________________________________
Phone Number: __________________________ Email: _________________________________
Street Address: __________________________ City: ______________________________ State: ______
Dates of treatment: __________________________ Focus of treatment: __________________________

Name: ______________________________ Type of Provider (Psychiatrist, Psychologist, Therapist, or
Other): ______________________________________
Phone Number: __________________________ Email: _________________________________
Street Address: __________________________ City: ______________________________ State: ______
Dates of treatment: __________________________ Focus of treatment: __________________________

Name: ______________________________ Type of Provider (Psychiatrist, Psychologist, Therapist, or
Other): ______________________________________
Phone Number: __________________________ Email: _________________________________
Street Address: __________________________ City: ______________________________ State: ______
Dates of treatment: __________________________ Focus of treatment: __________________________

Have you ever been hospitalized because of a mental health disorder, yes or no?
Yes: _____ No: _____. If you indicated that you have been hospitalized for a mental health
disorder, please complete the following information:
Reason for hospitalization:
___________________________________________________________________________

Was hospitalization voluntary or involuntary? Please check:
Voluntary: _____ OR Involuntary: ____
How long was your hospitalization?
___________________________________________________________________________

Where were you hospitalized?
___________________________________________________________________________

Course of treatment during hospitalization:
___________________________________________________________________________

Provide the name of the providers who treated you below. Please indicate the type of provider (i.e., Psychiatrist, Psychologist, MD, Licensed Therapist).

Name: ___________________________ Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):
___________________________________________________________________________
Phone Number: ___________________ Email: ____________________________
Street Address: ________________ City: ____________________________ State: __________
Dates of treatment: ____________________________________________________

Name: ___________________________ Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):
___________________________________________________________________________
Phone Number: ___________________ Email: ____________________________
Street Address: ________________ City: ____________________________ State: __________
Dates of treatment: ____________________________________________________

Name: ___________________________ Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):
___________________________________________________________________________
Phone Number: ___________________ Email: ____________________________
Street Address: ________________ City: ____________________________ State: __________
Dates of treatment: ____________________________________________________

Current Mental Health Treatment:
Are you currently participating in therapy or counseling? Yes: ____ No: _____ If YES, please complete the following information: ____________________________

Name of Current Provider: ________________________________________________
Type of provider: _______________________________________________________
Phone Number: ___________________ Email: ____________________________
Street Address: ________________ City: ____________________________ State: __________
Dates of Treatment: ____________________________________________________
Focus of Treatment: ____________________________________________________

(SAMPLE)
Name of Current Provider: _______________________________________________________ 
Type of Provider: _______________________________________________________________
Phone Number: ______________________ Email: ___________________________________ 
Street Address: ___________________ City: __________________ State: ____________ 
Dates of Treatment: ____________________________________________________________
Focus of Treatment: ____________________________________________________________

If you are currently receiving therapeutic services from another psychotherapist, to avoid a duplication of services, it may be necessary for me to contact your current psychotherapist to coordinate care. You may be required to sign and “Authorization for Release of Confidential Information” form which will be provided to you and maintained as part of your clinical record long with a copy of this patient intake form.* Please Initial: _______

If you are currently under the care of a psychiatrist, are you taking any prescribed psychiatric medication(s), yes or no? Yes _____ No_____. If you indicated that you are currently taking psychiatric medication, please list the type of medication, the specific medication you have been prescribed, the dosage, and any side effects in the space below.

For example: “Antidepressant (type), Zoloft (specific medication), 50mg once daily (dose), Insomnia (side effect).”

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

If you are currently under the care of a psychologist, have you participated in any psychological assessments or tests yes, or no? Yes ____ No_____. If you have participated in psychological testing, please list the type of test performed, the specific name of the test, and the date(s) the test(s) were administered.

For example: “Personality Test (Type), Minnesota Multiphasic Personality Inventory “MMPI-2” (Specific name of test), February 01, 2017 (Date test was administered).”

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
*California Civil Code Section, 56.10 states that information may be disclosed to “providers of health care or other health care professionals or facilities for purposes of diagnosis or treatment of the patient” without the patient’s consent. By initialing, you acknowledge and understand that I may contact either your current or former mental health care and/or medical providers only to discuss issues relevant to your diagnosis and treatment without your consent. Initial: __________

Medical Treatment Information:
Are you currently seeking treatment for a serious or chronic non-psychiatric medical condition, yes or no? Yes: _____ No: _____. If you currently have a medical condition, please provide the following information:

Current medical condition: ____________________________________________________________
How long have you had the condition? ________________________________________________
Is it a medically treatable condition, yes or no? Yes: ____ No: __________________________
If, it is not a medically treatable condition (i.e., palliative care), please describe:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

If you are currently taking prescribed medications for the condition please describe the type of medication, indicate how long you have been taking the medication, and any side effects.

For example: “High blood pressure medication (type of medication); 2 years (length of time on medication); Drowsiness (example of a side effect).
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Trauma History (Optional):
Have you been – or are you currently being – emotionally, physically, or sexually abused?
Yes _____ No _____ Prefer not to answer ____. If you checked “Yes,” you may use the space below to describe the underlying circumstances:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Family of Origin Information (Optional):
Were you adopted, yes or no? Yes: _____ No: ______. If you were adopted, at what age were you adopted? ______.
If you were adopted, do you have a relationship with your birth mother and/or father, yes or no? Yes: _____ No: _____ If yes, please describe the nature of the relationship. For example, explain how the relationship with your biological parent(s) was established, how old you were at the time the relationship began, the frequency of contact you had or currently have, and the nature of the relationship:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

If you were adopted, what type of relationship do you/did you have with your adopted parents?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

If you were not adopted, what type of relationship do you/did you have with your biological parents?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please provide the following information about your parents either (biological/adopted) or stepparent:

Name of Mother: __________________________
Name of Father: __________________________
Mother’s occupation: ______________________
Father’s Occupation: ______________________
Name of Stepmother: ___________________
Name of Steppather: ___________________
Stepmother’s Occupation: __________________
Stepfather’s Occupation: __________________
Are either of your parents (biological or adopted, and/or step parents) deceased? If your parents are deceased, please provide the following information:

- Mother/Stepmother has been deceased for ______ days/weeks/months/years. What was your age at the time of your mother’s/stepmother’s passing? ______
- Father/Stepfather has been deceased for ______ days/weeks/months/years. What was your age at the time of your father’s/stepfather’s death? ______

Indicate the marital status of your parents (biological/adopted). Check all that may apply:

- Currently married to each other for ______ years
- Currently separated for ______ years
- Divorced for ______ years
- Mother remarried ______ times
- Father remarried ______ times
- Mother currently single after being separated/divorced for ______ years
- Father currently single after being separated/divorced for ______ years
- Mother is currently involved with someone, yes or no? If yes, for how long? ______
- Father is currently involved with someone, yes or no? If yes, for how long? ______

Do you have any biological siblings, adopted siblings, step siblings, or half siblings, yes or no? Yes: ______ No: ______. If you have any siblings, how many? ______. In the space provided below, list the name and ages of each of your siblings and briefly describe the nature of your relationship as being “close,” or “not close,” or “estranged,” or any other word that describes the nature and extent of your relationship with your siblings.

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Which of the following statements most resonates with you:

- My parents were present during my entire childhood, yes or no? Yes: ______ No: ______. Explain: ____________________________________________

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

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- My parents were present during a part of my childhood, yes or no? Yes: _____ No: _____.
  Explain: ______________________________________________________________________________
  ______________________________________________________________________________
  ______________________________________________________________________________
  ______________________________________________________________________________

- My parents were not present at all during my childhood, yes or no? Yes: _____ No: _____.
  Explain: ______________________________________________________________________________
  ______________________________________________________________________________
  ______________________________________________________________________________
  ______________________________________________________________________________

Which of the following describes your childhood family experience:

- _____ It was an outstanding home environment
- _____ It was a normal home environment
- _____ It was a chaotic home environment
- _____ Prefer not to answer

If you indicated that your home environment was chaotic, please explain. For example, you may have witnessed physical/verbal/sexual abuse towards others, or you may have experienced physical/verbal/sexual abuse from others:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Mental Health/Risk Assessment:
Please identify if you have experienced any of the following and whether this is a past, current, or reoccurring issue:

- _____ Suicidal Thoughts.
  o Past: _____ Present: _____ Reoccurring: _____
- _____ Thoughts of wanting to intentionally harm myself.
  o Past: _____ Present: _____ Reoccurring: _____
- _____ Thoughts of wanting to intentionally cause harm to someone else.
  o Past: _____ Present: _____ Reoccurring: _____
- _____ Post-Traumatic Stress.
  o Past: _____ Present: _____ Reoccurring: _____
If you are currently experiencing any thoughts of either harming yourself or someone else please answer the following questions:

How long have you had these thoughts?
_____________________________________________________________________________

How frequently do you have these thoughts?
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Do you have a plan and/or the means to carry out either the threat of harm to yourself or to someone else, yes or no? Yes: _____ No: _____ If yes, please explain:
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Have you ever tried to harm yourself or anyone else in the past, yes or no? Yes: _____ No: _____ If yes, please explain:
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Is there anything that would stop, or prevent, you from harming yourself or someone else, yes or no? Yes: _____ No: _____ If yes, please explain?
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

If you indicated that there is not anything that would prevent you from harming yourself or someone else, please identify how likely it is that you might actually harm yourself or someone else:

Imminently likely: _____ OR Not at all likely: ______

Alcohol/Substance Use History (Optional):

Family Alcohol Abuse History: To the best of your knowledge, please indicate which of the following family member(s) struggles or struggled with alcohol/substance abuse or addiction:

Father: _____ Mother: _____ Grandparent(s): _____ Sibling(s): _____ Stepparent(s): _____
Uncle(s)/Aunt(s): _____ Spouse/Significant Other: _____ Children: _____
how well do you know your patient?

Please indicate your substance use status:

No history of use: _____ Actively using alcohol or drugs: _____ In early full remission: _____
In early partial remission: _____ In sustained full remission: _____
In sustained partial remission: _____

If you indicated that you have an alcohol/substance abuse or addiction history, please identify the types of treatment you have participated in, or are currently participating in, and how long you have been participating in the particular treatment.

Outpatient treatment:

_____________________________________________________________________________

Inpatient treatment:

_____________________________________________________________________________

12-Step Program:

_____________________________________________________________________________

Stopped using on my own:

_____________________________________________________________________________

Other Method:

_____________________________________________________________________________

Was the above treatment method effective? Please explain:

_____________________________________________________________________________

_____________________________________________________________________________

Please identify the type(s) of substances you are using, how frequently you use the substance, and how long you have been using the substance, and your frequency of use (i.e., daily, as needed, no regulation of use, etc.)

Opioid(s): _____ Classification: _____ Length of use: _____ Frequency of use: _____________

Heroin: _____ Length of use: _____ Frequency of use: __________________________________

Cigarettes/Tobacco: ____ Length of use: ____ Frequency of use: _________________________

Alcohol: ____ Length of use: ______ Frequency of use: ________________________________

Amphetamines: ____ Length of use: ______ Frequency of use: __________________________

Barbiturates: ____ Length of use: ____ Frequency of use: ______________________________

Cocaine: ____ Length of use: ____ Frequency of use: _________________________________

Crack: ____ Length of use: ____ Frequency of use: _________________________________
how well do you know your patient?

Hallucinogens: ______ Length of use: ___ Frequency of use: ________________________________

Inhalants: ______ Length of use: ___ Frequency of use: ________________________________

Marijuana: ______ Length of use: ___ Frequency of use: ________________________________

Other: ________ Length of use: ___ Frequency of use: ________________________________

If you have indicated that you have used, or are currently using substances, please indicate what side effects and or consequences you experienced or are experiencing as a result of the use.

Overdose: _____ Suicidal Impulse: ______ Depression: ______ Anxiety: __________
Blackouts: ______ Loss of control: ______ Medical conditions: ______ Other: _______

Please use the space provided to describe any other effects or consequences you have experienced:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Spiritual/Cultural History (Optional):
Do you identify with a particular religion, culture, or spiritual practice? If so, please describe:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Do any of the above religious, cultural, or spiritual issues contribute to your current concerns, problems, or issues? If so, please describe:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Additional Information

Please let me know in the space provided, of anything that was not addressed in this intake, and anything that you would like me to know about you, your goals, your relationships, or any recent significant life events:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Patient Signature: ____________________________________________ Date: __________