INTAKE FORM

Name ________________________________ DATE __________________

Address ________________________________

City ____________________ Zip Code ___________

DOB ________________________________

Soc. Sec. # ____________________________

Primary Phone __________________________ Cell or Landline

Work Phone ____________________________

Email ____

May we call and leave a message with you?

Cell _____ Home _____ Work _____ Email _____

It would be our pleasure to send you an appointment reminder by email or text. The appointment reminder will include only the date and of your appointment and your service provider name. We will not encrypt the messages. Health care information sent by regular e-mail could be lost, delayed, intercepted, delivered to the wrong address, or arrive incomplete or corrupted. If you understand these risks and would like to receive an appointment reminder by email, I need you to confirm you accept responsibility for these risks, and will not hold us responsible for any event that occurs after we send the message.

Accept _____ Preferred method: Text ____ or Email _____

Decline _____

Emergency contact Name and Phone: ____

INSURANCE BENEFITS FOR DATA COLLECTION PURPOSES ONLY

Do you have Insurance coverage?

If so what is the name of the insurance company?

Does it include Substance abuse treatment coverage?

Center for Interpersonal Effectiveness, PC

2525 N. Ankeny Blvd. Suite 113 • Ankeny, IA 50021
515-289-9136 515-289-9139 (Fax)

GENERAL INTAKE INFORMATION

Referred By: ____

Reason for Referral:

____

____

____

____

MENTAL HEALTH INFORMATION:

Please check any of the following that you have experienced recently:

☐ Depression	☐ Anxiety	☐ Sleep disturbance	☐ Suicidal thoughts
☐ Panic attacks	☐ Paranoia	☐ Appetite problems	☐ Stealing
☐ Compulsive behaviors	☐ Weight loss/gain	☐ Racing thoughts	☐ High Energy
☐ Low energy	☐ Poor attention	☐ Social withdrawal	☐ Anger/irritability
☐ Distractibility	☐ Aggression	☐ Poor concentration	☐ Blackouts
☐ Hyperactivity	☐ Memory problems	☐ Other(s)____________________	

Have you received mental health treatment before? ☐ Yes ☐ No
If so, when and where?

____

____

____

____

SUBSTANCE USE INFORMATION:

Alcohol: _____ Never used ____Currently using ____ Past use ____Age first used
Amphetamines _____ Never used ____Currently using ____ Past use ____Age first used
Anti-anxiety (e.g. Valium) _____ Never used ____Currently using ____ Past use ____Age first used
Barbiturates _____ Never used ____Currently using ____ Past use ____Age first used
Cocaine/crack: _____ Never used ____Currently using ____ Past use ____Age first used
Heroin/morphine: _____Never used ____Currently using ____ Past use ____Age first used
LSD/acid _____ Never used ____Currently using ____ Past use ____Age first used
Marijuana/hash: _____ Never used ____Currently using ____ Past use ____Age first used
Meth/Crystal meth: _____Never used ____Currently using ____ Past use ____Age first used
Painkillers (e.g.Oxycontin) _____Never used ____Currently using ____ Past use ____Age first used
Other (specify) __________ _____Never used ____Currently using ____ Past use ____Age first used

Describe type, amount and frequency of use for each substance indicated above:

Have you been treated for alcohol/drug problems before? ☐ Yes ☐ No
If so, when and where?

FAMILY/HOME INFORMATION: List people living in the home:

Name	Age	Relationship to client

MEDICAL/HEALTH INFORMATION:

Do you have any current or ongoing medical problems? ☐ Yes ☐ No
If so, please explain:

Who is your primary doctor/medical provider?

Name	*City*	*Phone number*

What medications do you take? Include non-prescription, herbal medicines and supplements.

Medicine	Dose	Frequency	Who prescribes

Please list any allergies, including medication allergies/sensitivities: