InnerVision Therapy, LLC
Intake Form

For Office Use Only
DSM code ___________
Visit Code ___________

Patient Information

Name ____
Nickname _________________________ **Date of Birth** ______/______/_______
SSN (Required by INS) _______-_____-_______ **Gender** ☐ Male ☐ Female
Marital Status ☐ Married ☐ Single ☐ Other **Significant Other Name** ___________________
Sig/Other Gender ☐ Male ☐ Female Yrs Together ________ Sig Other Age ________
Names/Ages of Children ____
Address ____
City/State/Zip _________________________ ______ ____________________________
Employment ☐ Employed ☐ F/T Student ☐ P/T Student ☐ Unemployed/Other

How may we contact you?

Mobile Phone _______-_______-_______ ☐ Voice Msg ☐ Text ☐ Both ☐ No
Home Phone _______-_______-_______ ☐ Voice Msg ☐ Text ☐ Both ☐ No
Work Phone _______-_______-_______ ☐ Voice Msg ☐ Text ☐ Both ☐ No
Other Phone _______-_______-_______ ☐ Voice Msg ☐ Text ☐ Both ☐ No
Preferred Phone # ☐ Mobile ☐ Home ☐ Work ☐ Other
Email Address ___________________________________

Contacts

Name: ___________________________
Company ___________________________
Contact Type ☐ PCP ☐ Emergency Contact ☐ Guardian
Relationship ☐ Spouse ☐ Parent ☐ Child ☐ Guardian
Address Line 1 ____
Address Line 2 ____
City/State/Zip _________________________ ______ ____________________________
Mobile Phone __________________________________
Home Phone __________________________________
Work Phone __________________________________
Other Phone __________________________________

Insurance Info

Insurer _________________________________ **ID#** ______________________________
Group # _________________________ **Relationship to Insured** ☐ **Self** ☐ **Spouse** ☐ **Child**
Insured's Name _________________________ **DOB** _____/_____/_____ **SSN** ______-_____-_______
Insured's Employer _________________________ **Phone #** ____________________________

I hearby consent for InnerVision Therapy to provide evaluation and treatment to me.

Signature ____ **Date** ________/________/_________

InnerVision Therapy, LLC

Medical and Health History

Name ____ Date _____/_____/_____

Allergies ____

Primary Care Physician ____

PCP Address ____

City/State/Zip ________________________ _________ ____________________________

PCP Phone # ______-______-________

Date of last Phsyical Exam _____/_____/_____

Therapists you have seen

Therapist's Name ________________________ Date _____/_____/_____

Therapist's Name ________________________ Date _____/_____/_____

Therapist's Name ________________________ Date _____/_____/_____

Therapist's Name ________________________ Date _____/_____/_____

Substance Abuse/Inpatient Psychiatric Treatment

Date _____/_____/_____ Describe _______________________________

Date _____/_____/_____ Describe _______________________________

Date _____/_____/_____ Describe _______________________________

Date _____/_____/_____ Describe _______________________________

Current Medications and Dosages

Medication	Dose	Name of Prescribing Doctor	Date you began taking it

Current or Past Health Problems	

Substances Currently Used		
Substances	**Amount Used**	**How Often**
Cigarettes		
Alcohol		
Pills not prescribed for me		
Marijuana		
Cocaine or crack		
LSD		
Heroin		
Other (please list)		

How did you hear about InnerVision Therapy? ____

What kind of problems bring you to InnerVision Therapy?

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InnerVision Therapy, LLC

Indicate whether the client is having any of the following problems, or if they had them in the past.			
	Present	**Past**	**N/A**
Difficulty falling or staying asleep			
Sleeping too much			
Change in appetite, weight loss, or weight gain			
Made myself throw up in order to lose weight			
Used laxatives or exercised excessively to lose weight			
Frequent crying			
Panic attacks or anxiety attacks			
Thoughts of killing or hurting myself			
Attempts to kill or hurt myself			
Problems concentrating			
Problems remembering things			
Periods of daily sadness lasting more than two weeks			
Feelings of guilt			
I startle easily			
Can't stop remembering upsetting past events			
Difficulty controlling my temper			
I physically hurt people			
I break things sometimes			
I worry a lot			
Little or no interest in sex			
I feel tired almost every day			
Feelings of unreality			
I often feel like an outsider			
Worry that something is wrong with my body			
Frequent arguments with the people I live with			
I hear voices inside my head			

Other (please list) : ____

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