Boules Clinical Psychology Group, PLLC

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REGISTRATION AND INTAKE FORM

Name _____ Date_____

Address _____

_____

Date of Birth_____ Marital Status_____

Home Phone (_____)_____ Mobile Phone (_____)_____

Email address _____

Preferred method of contact _____ May we leave a message? YES NO

Emergency contact _____ Relationship _____

Contact phone number) (_____)_____

Why are you here today? Include symptoms and duration of symptoms:

_____

_____

_____

Have you ever been treated for a psychiatric disorder? YES NO

If yes, when and where did you receive treatment? _____

Name of your past mental health provider(s)? _____

What type of treatment did you receive (Medication, Inpatient, Outpatient)?

_____

Do you drink alcohol currently? If so, how much and how often? _____

Have you ever been treated for alcohol or substance abuse related problems? YES NO

If so, when and where? _____

Are you currently using illicit substances? YES NO

If so, which drug(s), how much and how often? _____

What medical problems do you have presently or have had in the past?

_____

_____

Please list any previous surgeries:

_____

_____

Have you ever had a head injury? YES NO

If yes, please specify: _____

Please circle any symptoms you are presently experiencing:

Trouble with Vision	Cough, fever or chills	Unexplained bruises
Trouble with Hearing	Nausea or vomiting	Weakness, numbness or tingling
Headaches	Diarrhea or constipation	Cold intolerance
Trouble chewing or swallowing	Trouble or pain while urinating	Other:
Chest pain	Muscle Aches or pains	
Shortness of breath	Joint pain or swelling	
Heart palpitations	Rashes	

Please list prescribed and over the counter medications, vitamins and dietary supplements you're taking

Name of Medication or supplement	**Dose/Frequency**	**Length of time taking this Medication**	**Prescribing Physician (if applicable)**

Please list any allergies you have:

_____

_____

Do any members of your family have a history of psychiatric disorders, including suicide attempts or completion? Please specify:

_____

_____

Where and with whom did you grow up?

_____

_____

How would you describe your childhood?

_____

_____

Do you have any history of having been physically, sexually or emotionally abused? YES NO

If so, please specify: _____

Highest level of education completed: _____

Do you have children? YES NO

If so, please list names and ages:

_____

_____

With whom do you live: _____

Did you serve in the Armed Forces? YES NO

If so, please specify: _____

What is your current occupation? _____

Please list individuals who make up your support system:

_____

_____

What are your interests and hobbies?

_____

_____

What are your personal strengths?

_____

_____

Is there anything else you feel is important for us to know?

_____

_____

How did you hear about our practice/who referred you? _____

Would you like to receive monthly Newsletters? YES NO