patterns
Dr. Kauliss P. Lanthier, *C. Psych*

INTAKE FORM

Date _____/_____/_____
dd/mm/yyyy

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ Age: _____ Gender: □ Male □ Female
dd/mm/yyyy

Marital Status: □ Never Married □ Domestic Partnership/Civil Union □ Married
□ Separated □ Divorced □ Widowed

Please list any children/age: _____

Address: _____
(Street and Number)

_____
(City) (Parish) (Zip)

Home Phone: ( ) _____ May I leave a message? □ Yes □ No

Cell/Other Phone: ( )_____ May I leave a message? □ Yes □ No

E-mail: _____ May I email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact Name: _____ Relationship to you? _____
Telephone Number: _____

Insurance Company Name and Address:_____

Identification/Certificate #: _____ Policy/Group#: _____

Responsible Party Name and Date of Birth (if other than self): _____
_____

Referred by (if any): _____

_____

EMPLOYMENT INFORMATION

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation: □ Full Time □ Part-time □ Unemployed
□ On Disability □ Minor/not employed

Employer Name _____

Employer Address _____

Job Title: _____

If Student: □ Full-time □ Part-time School/College _____

School Address: _____

2. Do you enjoy your work/school? Is there anything stressful about your current work/school?

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Name of Primary Care Physician (PCP): _____

PCP Address & Phone: _____

1. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No □ Yes Name of Therapist(s): _____

Have you ever been prescribed psychiatric medication? □ Yes □ No

Please list and provide dates: _____

_____

2. How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

_____

3. How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

4. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

5. Please list any difficulties you experience with your appetite or eating patterns:

_____

6. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes, for approximately how long? _____

7. Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this? _____

8. In the past few weeks, have you felt that you or your family would be better off if you were dead? □ No □ Yes

9. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe _____

10. Do you drink alcohol more than once a week? □ No □ Yes

11. How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

12. Are you currently taking any prescription medication? □ Yes □ No

Please list: _____

_____

13. Do you have any allergies? _____

14. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

15. What significant life changes or stressful events have you experienced recently?

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	

Domestic Violence	yes/no
Eating Disorders	yes/no
Obesity	yes/no
Obsessive Compulsive Behavior	yes/no
Schizophrenia	yes/no
Suicide Attempt	yes/no

ADDITIONAL INFORMATION:

1. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

2. What do you consider to be some of your strengths?

_____

_____

3. What do you consider to be some of your weakness?

_____

_____

4. What is the nature of the concern you wish to address in therapy?

_____

_____

5. Therapy can be a powerful force for change. For it to be most effective it helps to list clear and specific goals. Please express your hopes for therapy in the form of specific goal (s).

- _____
- _____
- _____
- _____
- _____

6. Please express your hopes for therapy in the form of outcome? How will you know you have benefitted from treatment?

- _____
- _____
- _____

Office Use Only: Therapist _____ Dx: _____