GILEAD
COMMUNITY SERVICES, INC. • Serving Middlesex County
Improving Lives, Building Futures

Middletown Outpatient Clinic Intake

Identifying Information:

Name: _____ Gender**:** ☐ Male ☐ Female

Date of Birth: _____ Social Security Number: _____

Home Phone Number: _____ Cell Phone Number_____

Address: _____

Email Address**:** _____

Emergency Contact: (Name and Number)**:** _____

Preference for appointment reminders: ☐ email ☐ home phone ☐ cell phone

Demographics:

Race: ☐ American Indian/Native American ☐Asian ☐Black/African American ☐Other ☐White/Caucasian

Ethnicity: Hispanic? ☐ Yes ☐ No ☐ Decline to answer; if yes, please specify. _____

Do you smoke or use tobacco products**?** ☐ Yes ☐ No

Are you currently or have you been in the Military? ☐Yes ☐ No If yes, please list dates and branch of service. _____

Family and personal history:

☐ Married ☐Divorced ☐ Widowed ☐ Separated ☐Single

Do you have any children? _____

How many brothers/sisters do you have? _____

Is there a history of emotional or psychiatric illness in your family? ☐ Yes ☐ No If yes, briefly comment:
_____

_____

_____

Employment and Education:
Are you currently employed? ☐Yes ☐ No Employer: _____

Education: ☐ High School Graduate (or highest grade attended _____) ☐ Some College ☐ College Graduate ☐ Graduate Degree

Social Support and Leisure
Over past year, describe social relationships, friendships, support networks, leisure activities: _____

_____

_____

_____

_____

Do you identify with any organized religion, spiritual practice or belief? ☐ Yes ☐ No If yes, describe.

_____

Clinical Information

What services are you seeking?

☐Individual Therapy, ☐Group Therapy, ☐Marital or Couples Therapy ☐Medication Management

(Please describe your current symptoms or stress related problems such as relationships, work, health, legal or financial problems.)

_____

_____

_____

_____

_____

_____

What are your treatment goals? _____

_____

_____

What are some of your strengths? _____

_____

_____

_____

Treatment History

Have you ever been treated for emotional or psychiatric issues before? ☐ Yes ☐No

If yes, please list date (approximate) and where you were treated:

_____

_____

_____

_____

_____

Have you ever been treated for alcohol or substance use issues? ☐ Yes ☐ No

If yes, please list date (approximate) and where you were treated:

_____

_____

_____

Are you currently being prescribed medication for emotional or psychiatric problems? ☐ Yes ☐ No
If yes, complete the following:

Name of Medication(s):_____

Name of Phone Number of MD/APRN:

_____

How long have you taken these medications? _____

Do you have a primary care physician? ☐ Yes☐ No If yes:

Name and phone number of MD/APRN _____

Are you being treated for any medical problems? ☐ Yes ☐ No If yes please describe:

_____

_____

Are you allergic to any medications? ☐Yes ☐ No If yes, please list::

_____

_____