## 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.

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**_ 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: