The Atrium
4 Terry Drive, Suite 11, Newtown, PA 18940
Phone: 215-550-1818
e-mail: admin@buckscountyanxietycenter.com
www.buckscountyanxietycenter.com

Intake Form

Contact Information:

Name:

Address:

Telephone: Home: Ok to leave detailed message: YES NO

Cell: Ok to leave detailed message: YES NO

Work: Ok to leave detailed message: YES NO

E-mail:

Date of birth:

Marital status:

Number of children, gender, ages:

Occupation: Current job:

Emergency Contact:

Name: Phone number:

Relationship to you:

This information is requested in the event of a psychiatric emergency. No information will be given to anyone about your treatment status or appointments without your expressed permission.

Payment:

- All payment is due at your session. Patients may not carry a balance.
- You may pay for sessions by cash, credit card, or check.
- Make checks out to **Bucks County Anxiety Center.** There is a $30 fee for returned checks.
- Phone sessions are pre-billed.

By filling out the information below, you acknowledge that any outstanding balances will be automatically charged to your credit card.

Card type:

Name on card:

Card number:

Security code:

Expiration date:

Signature:

_____Please charge all sessions directly to this credit card (Your Initials:)

Referral Source:

How did you hear about this practice?

Doctor OT PT Psychiatrist Psychologist/Social Worker Google Psychology Today
Other:

Working with Your Therapist (please use the back or attach another page if you need more space):

- What brings you in to work with me?

- What is your history with this issue?

- What are your goals?

- How will you know when you have achieved these goals?

- What challenges do you anticipate?

- What kind of supports do you have in place?

- What are some important things you want me to know about you?

Medical Information:

Primary care physician:

Primary care physician's phone number:

Date of last physical:

Have you been diagnosed with any medical conditions? Please list all and date of diagnosis.

Are you currently being treated for any medical conditions? Yes No

- If yes, please list condition, treatment, and impact on your daily functioning. Use the back of this page or add an extra form if needed. Please attach any articles you want your therapist to read.

Have you ever been diagnosed with any mental health conditions? Please list all and date of diagnosis.

Medications you are currently taking (include reason for taking them, dose, and frequency):

Medical Information Continued:

Are you currently taking medications for a mental health issue? Yes No

- If yes, please list name of medication, dose, frequency, and reason you are taking it:

- Name of doctor prescribing the medication:
  - This doctor is a:
    - General Practitioner
    - Psychiatrist
    - Other_____

Are you currently taken any supplements, essential oils, or herbal remedies? Yes No

- If yes, please list what you are taking, dose, frequency, and reason you are taking it:

Have you ever been hospitalized for psychiatric reasons? Yes No

- If yes, please list dates, length of hospitalization, and reasons for admission:

Other Specialists You See (e.g., PT, OT, alternative medicine, psychiatrist, pain management):

Specialist #1:

Name:

Address:

Phone number:

May I contact this specialist to let them know we are working together? Yes No

Specialist #2:

Name:

Address:

Phone number:

May I contact this specialist to let them know we are working together? Yes No

Recreational Drug Use

- What are you using? (this includes inhalants and pills of any kind)

- How often?

- Are you hiding this from anyone? If yes, who?

- Who do you use with?

- Do you ever use alone? If so, when?

- How does drug use help you?

Alcohol Use

- How many times a week are you drinking?

- What do you drink?

- Are you hiding this from anyone?

- Do you ever drink alone?
    - If yes, when?

- How does drinking help you?

High Risk Activities:

Please indicate if you've ever done any of these activities, how often, and whether it's happening now or happened in the past.

Activity	How often	Currently Doing This	Did this in the past
Driving while drunk/high			
Operating a boat or any other kind of machine while drunk or high			
Exchanging money for sex			
Selling drugs or pills			
Buying drugs or pills			
Gambling			
Having unprotected sex			
Stealing money or things			

Background Information:

Have you every been arrested? If yes, for what?

Have you ever spent time in prison? If yes, for what?

Have you ever been fired from a job due to illegal behavior? If yes, on what grounds?

Have you ever been investigated by Child Protective Services? If yes:

When:

Reason:

Outcome:

Developmental and Educational Information

- Must be filled out for all children and teens.
- Please complete if you are a young adult (up to age 25) who has ever been diagnosed with ADHD, a learning difference, Asperger's, sensory processing disorders, or any issue impacting your ability to make it through school easily and/or make friends.

Current Grade:

Current School:

Academic Strengths:

Academic Struggles:

Does the child have an IEP and/or 504 in place? If so, why? What accommodations are in place? Please bring in a copy of the IEP, 504, and any psychological or educational testing results.

Did the mother experience any complications during pregnancy?

Was this child born at term?

If no:

- Gestational age at birth:
- Amount of time in NICU:
- Trouble with temperature regulation, eating, digestion, breathing, heart rate, etc.:

Developmental and Educational Information:

Did the child reach all their developmental milestones on time? If no, please explain.

What is the child/teen's overall temperament and personality? What are they like?

How does this child/teen cope with stress?

What is the greatest cause of stress for this child/teen right now?

How are this child/teen's relationships with their:

- Family:
- Friends:
- Class/School mates:
- Teachers/Coaches:

Client Consent:

By signing this form, I am providing consent for my therapist at Bucks County Anxiety Center to treat me and/or my child.

I have read the parts of this document outlining practice policies regarding payment. I understand them and agree to comply with all the policies and procedures described in this document.

Patient name: Signature:

Parent/guardian name: Signature:

Date: