

# The Barrington Center for Counseling and Psychotherapy

## INTAKE HISTORY

Therapist: \_\_\_\_\_

### Patient Information

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

### Responsible Party Information *(if minor or dependent is involved)*

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### Insurance Information *(please attach Insurance card to clipboard for verification)*

Insured's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_ Group / Plan Number: \_\_\_\_\_

Insured's Social Security #: \_\_\_\_\_ Insurance Company Phone: \_\_\_\_\_

**FOR OFFICE USE ONLY:** DX: \_\_\_\_\_ Session Fee: \_\_\_\_\_

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## Additional Information

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

School Name (if minor): \_\_\_\_\_ Grade: \_\_\_\_\_

May we contact you at home? \_\_\_ YES \_\_\_ NO Cell? \_\_\_ YES \_\_\_ NO Work? \_\_\_ YES \_\_\_ NO

How were you referred to our practice? \_\_\_\_\_

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## General Information

The reason you have come to the Barrington Center (primary complaint):

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People living in the household (names, ages and relation):

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Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_

Do you enjoy your work? \_\_\_\_\_ YES \_\_\_\_\_ NO

Educational level completed (current students circle current / former students circle last)

**GRADE SCHOOL**

**HIGH SCHOOL**

**COLLEGE**

**GRADUATE SCHOOL**  
(or others)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are your parents living: Mother: \_\_\_\_\_ YES \_\_\_\_\_ NO Father: \_\_\_\_\_ YES \_\_\_\_\_ NO

If no, please specify cause of death and age: \_\_\_\_\_

Number of brothers: \_\_\_\_\_ Ages: \_\_\_\_\_

Number of sisters: \_\_\_\_\_ Ages: \_\_\_\_\_

Number of children: \_\_\_\_\_ Ages: \_\_\_\_\_

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## Medical Condition

Current Doctor: \_\_\_\_\_

Office / Hospital: \_\_\_\_\_

Current Medical Conditions (*main*):

How long have you had this condition?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been hospitalized for depression or anxiety?     YES     NO

Name of Psychiatrist: \_\_\_\_\_

## Current Medications

Name of Medication:

Dosages/Frequency

For what condition?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Leisure

What do you enjoy doing when you aren't working? How often? (*daily, weekly, other*)

\_\_\_\_\_  
\_\_\_\_\_

## Spiritual

Are you religious/spiritual?     YES     NO

Do you meditate?     YES     NO

If yes, how do you express your religious/spiritual side? \_\_\_\_\_

\_\_\_\_\_

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## Social Support

Do you see yourself living in a supportive environment? *(Circle appropriate number)*

Not Well –     1    2    3    4    5    6    7    8    9    10     – Very Well

At this time, what is the stress level in your life?

No Stress –     1    2    3    4    5    6    7    8    9    10     – High Stress

## Mental / Physical Information

Have you experienced: *(please check all that apply)*

- |   |  |
|---|--|
| <input type="checkbox"/> Lack of Motivation               | <input type="checkbox"/> Hyperactivity   |
| <input type="checkbox"/> Irritability                     | <input type="checkbox"/> Worthlessness   |
| <input type="checkbox"/> Chronic Worry                    | <input type="checkbox"/> Sleep Disturbances  |
| <input type="checkbox"/> Depressed Mood                   | <input type="checkbox"/> Grief   |
| <input type="checkbox"/> Decreased Energy                 | <input type="checkbox"/> Hopelessness  |
| <input type="checkbox"/> Anxiousness                      | <input type="checkbox"/> Panic Attacks   |
| <input type="checkbox"/> Increase/Decrease in Eating      | <input type="checkbox"/> Obsessions/Compulsions  |
| <input type="checkbox"/> Decrease in Social Relationships | <input type="checkbox"/> Attention/Concentration Problems  |
| <input type="checkbox"/> Decrease in Family Relations     | <input type="checkbox"/> Racing Thoughts   |
| <input type="checkbox"/> Suicidal Thoughts                | <input type="checkbox"/> Substance Use Past / Present<br><i>(alcohol, marijuana, cocaine, other)</i> |
| <input type="checkbox"/> Other: _____                     |  |

## Health Habits *(please mark if answer is "yes"):*

Smoke \_\_\_\_\_     Drink alcohol \_\_\_\_\_     Eat a lot of sweets \_\_\_\_\_

Do you exercise? \_\_\_\_\_     Frequency and type: \_\_\_\_\_

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