PATIENT INTAKE:
PART ONE: PATIENT IDENTIFYING INFORMATION:

_____ _____ _____
last first preferred name

_____
birthday

_____ _____
gender gender pronouns

_____ _____
home telephone mobile telephone

_____
email

Calls will be discreet, but please indicate any restrictions and/or preferences:

_____

_____

_____

_____

MARITAL STATUS:

☐ ☐ ☐ ☐

single/never married divorced/separated partnered/married
widowed

EMERGENCY CONTACT:

_____
name

_____
relationship (i.e. friend, relative, physician, etc.)

_____ _____
home phone mobile

PART TWO: PSYCHIATRIC HISTORY

Are you/your child in treatment with another mental health professional?

☐ ☐

yes no

---

name

Have you/your child ever had psychological treatment?

☐ ☐

yes no

---

with whom?

What is your current diagnosis?

What medications are you currently taking?

Who is your current psychiatrist?

---

name

_____

_____ _____

phone fax

CHILD PATIENTS ONLY

Parent/Guardian Information:

_____

name

_____ _____

age education level

_____ _____

home phone mobile phone

_____

email

Parent/Guardian Information:

_____

name

_____ _____

age education level

_____ _____

home phone mobile phone

_____

email

Child's School: _____

Grade: _____

Special Education Plan: Yes or No

PART THREE: REFERRAL

How did you hear about us?

☐ friend ☐ family member ☐ CCBTC website ☐ healthcare provider ☐ other _____
(please specify)

If a healthcare provider referred you please tell us their name, place of business and relationship to you:

_____

_____

_____

_____

_____