INSIGHTFUL DIRECTION
YOUR JOURNEY, YOUR DIRECTION.

Insightful Intake

Contact Information and Demographics

First Name: _____ Middle: _____
Last Name: _____ Maiden: _____
Preferred Name: _____
Date of Birth: _____/_____/_____ SSN#: _____–_____–_____
Sex: M / F / Other
Marital Status: Single Married Divorced Separated Widowed
Ethnicity/Race: White Black Asian Hispanic
American Indian/AK Native Nat. HI /Pacific Islander
Home Address: _____ Apt/Unit: _____
City, State, Zip: _____

Mailing Address: _____
City, State Zip: _____

Mobile: (_____)_____-_____ ____ (X the preferred method of contact)
Work: (_____)_____-_____ ____
Home: (_____)_____-_____ ____
Other: (_____)_____-_____ ____

Email: _____

(Optional)
Emergency Contact Name: _____
Phone Number: (_____)_____-_____
Relationship: _____

*Please sign as permission to contact above listed in case of posed risk to self, hospitalization, or medically compromised. Therapeutic details and extent of relationship with Michael will remain confidential. This will be updated regularly.

Signature: _____Date: _____

Insurance and Primary Care Information

Primary Insurance: _____
Phone Number: (_____)–_____–_____
ID#: _____Group#: _____
Policyholder Name: _____
Policyholder Address: _____
City, State Zip Code: _____
Relationship to Patient: Self Spouse Parent Guardian

Primary Care Provider:_____
Practice Name: _____
Phone Number: (_____)–_____–_____
Fax Number: (_____)–_____–_____
Practice Address: _____
City, State, Zip: _____

Other Care Provider:_____
Practice Name: _____
Phone Number: (_____)–_____–_____
Fax Number: (_____)–_____–_____
Practice Address: _____
City, State, Zip: _____

Would it be helpful to have contact with your Primary Care Provider?: Y / N
Would it be helpful to have contact with your other Healthcare Provider?: Y / N

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Psychiatric History

What brings you in?

_____
_____
_____
_____
_____
_____

Are you experiencing any of these symptoms:?

( ) Depressed mood	( ) Unable to enjoy activities	( ) Sleep pattern disturbance
( ) Loss of interest	( ) Concentration/forgetfulness	( ) Change in appetite
( ) Excessive guilt	( ) Fatigue	( ) Decreased libido
( ) Racing thoughts	( ) Impulsivity	( ) Increase risky behavior
( ) Increased libido	( ) Decrease need for sleep	( ) Excessive energy
( ) Increased irritability	( ) Crying spells	( ) Excessive worry
( ) Anxiety attacks	( ) Avoidance	( ) Hallucinations
( ) Suspiciousness	( ) _____	( ) _____

How long have the particular symptoms been occurring?: _____ wks/mos/yrs

Have you experienced psychotherapy before: Y / N

If yes, how many therapists have you seen?: _____

When did you go/what ages? (1)_____ For how long (1) _____ wks/mos/yrs
(2)_____ For how long (2) _____ wks/mos/yrs
(3)_____ For how long (3) _____ wks/mos/yrs
(4)_____ For how long (4) _____ wks/mos/yrs
(5)_____ For how long (5) _____ wks/mos/yrs

Have your current issues been discussed with former psychotherapists? : Y / N

Do you have any concerns, questions, or curiosities (re)starting psychotherapy?: Y / N

_____
_____
_____
_____
_____
_____

Are you currently taking any psychiatric medication?: Y / N

If yes, what medication have you been prescribed?:

Med: (1)_____ Dsg: _____ Time of day or times/day: _____
Med: (2)_____ Dsg: _____ Time of day or times/day: _____
Med: (3)_____ Dsg: _____ Time of day or times/day: _____
Med: (4)_____ Dsg: _____ Time of day or times/day: _____
Med: (5)_____ Dsg: _____ Time of day or times/day: _____

Have you taken (other)psychiatric medication in the past?: Y / N

Med: (1)_____ Dsg: _____ Time of day or times/day: _____
Med: (2)_____ Dsg: _____ Time of day or times/day: _____
Med: (3)_____ Dsg: _____ Time of day or times/day: _____
Med: (4)_____ Dsg: _____ Time of day or times/day: _____
Med: (5)_____ Dsg: _____ Time of day or times/day: _____

How long have you been taking current medication?:

Med: (1)_____ For how long?: (1)_____ wks/mos/yrs
Med: (2)_____ For how long?: (2)_____ wks/mos/yrs
Med: (3)_____ For how long?: (3)_____ wks/mos/yrs
Med: (4)_____ For how long?: (4)_____ wks/mos/yrs
Med: (5)_____ For how long?: (5)_____ wks/mos/yrs

Are you taking or have taken any mood enhancing supplements?: Y / N

If yes, what supplements?:

Supplement: (1)_____
What For?:_____
Supplement: (2)_____
What For?:_____
Supplement: (3)_____
What For?:_____

Do you feel that the medication or supplement has helped?: Y / N

What changed?:

_____
_____
_____
_____
_____

Would it be helpful to have contact with your former Psychotherapists?: Y / N

Would it be helpful to have contact with your former Prescribers?: Y / N

Have you ever been hospitalized?: Y / N

If yes, what is your understanding as to why?

_____

_____

_____

_____

_____

How many times have you been hospitalized?: _____

Were you section against your will?: Y / N

Have you ever voluntarily sectioned yourself?: Y / N

Were the police ever involved?: Y / N

Where was your last hospitalization?: _____

How long?:_____ dys/mos/yrs When?: _____

Where was your longest hospitalization?: _____

How long?:_____ dys/mos/yrs When?: _____

Have you ever participated in a rehab or detox facility?: Y / N

If yes, what was the reason?

_____

_____

_____

_____

_____

How many times were you in rehab/detox?: _____

Were you sectioned against your will?: Y / N

Have you ever voluntarily sectioned yourself?: Y / N

Were the police ever involved?: Y / N

Where was your last rehab/detox?: _____

How long?: _____ dys/mos/yrs When?: _____

Where was your longest rehab/detox?:_____

How long?: _____ dys/mos/yrs When?: _____

Were criminal or civil charges ever filed for any sectioning?: Y / N

Would it be helpful to have contact with any former Hospitals?: Y / N

Would it be helpful to have contact with any former Facilities?: Y / N

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Medical History

Have you ever had or currently have any of the following medical conditions?

( ) Heart disease	( ) High blood pressure	( ) Diabetes
( ) Cancer	( ) Ulcers	( ) Digestive problems
( ) Bowel problems	( ) Urinary problems	( ) Liver disease
( ) Thyroid disease	( ) Skin disease	( ) Respiratory disease
( ) Multiple Sclerosis	( ) Neurological problems	( ) TBI
( ) Concussion	( ) Seizures	( ) Parkinson's disease
( ) Meningitis	( ) Encephalitis	( )Hepatitis A, B, C
( )Tuberculosis	( )HIV/AIDS	( )STD's/ STI's
( )Testicular/Prostate issues	( )Gynecological problems	( )Pregnancy
( )Menstrual problems	( )Cystic breasts	( )Endometriosis
( )Ovarian cysts	( )Hearing impairments	( )Vision impairments
( )Stroke	( )Epilepsy	( )Migraines
( )Alcohol Abuse	( )Drug abuse	( )Depression
( )Anxiety	( )Bipolar	( )Schizophrenia
( )Eating disorder	( )Plastic Surgery	
( )Other_____		

Do you have any allergies?: Y / N _____

Are you on any Medications for these conditions?: Y / N
If yes, what medication have you been prescribed?:

Med: (1)_____ Dsg: _____ Time of day or times/day: _____
Med: (2)_____ Dsg: _____ Time of day or times/day: _____
Med: (3)_____ Dsg: _____ Time of day or times/day: _____
Med: (4)_____ Dsg: _____ Time of day or times/day: _____
Med: (5)_____ Dsg: _____ Time of day or times/day: _____

Do you use any drugs?: Y / N / Quit How often?: _____ per day/week/month
Do you smoke tobacco?: Y / N / Quit How often?: _____ packs per day/week/month
Do you drink alcohol?: Y / N / Quit How often?: _____ drinks per day/week/month

Do you sleep well?: Y / N / Varies How many hours per night?:_____
Do you have an appetite?: Y / N / Varies How many meals per day?:_____
Do you exercise weekly?: Y / N How often ?:_____ days per week

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Legal History

Are you currently involved in any legal matters?: Y / N
Are they criminally based?: Y / N
Have you ever been arrested?: Y / N
How many times?: _____
Have you ever incarcerated?: Y / N
How many times?: _____
Overall, how long?: _____ dys/mos/yrs
What are/were the legal matters/charges?:

_____
_____
_____
_____

Are you on probation?: Y / N Is Psychotherapy part of your adjudication?: Y / N
Have you been assigned to any other adjudicated program (i.e. IOP, SOAP, DOVE)?: Y / N

_____
_____
_____
_____

Are any other State Departments involved with you at this time (i.e. DCF, DMH, DOR)?: Y / N
If so, which ones: _____

Social and Occupational History

What is your occupation?: _____How many hours do you work/week?:____
What is your highest level of education?: _____
What was your degree/study/profession?: _____
Do you own a home?: Y / N Do you live alone?: Y / N Do you have children?: Y / N
Are you currently or have you ever been currently considered "Disabled?": Y / N
Are you receiving any financial support because of your disability?: Y / N
What is your monthly income? $_____
What are of your recreational/leisure activities and how often do you socialize with others:

_____
_____
_____

Would contact with your Probation Officer be helpful?: Y / N
Would contact with another State Department worker be helpful?: Y / N

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Contact Release Information: Office Use Only

Psychotherapist: _____
Practice Name: _____ Location: _____
Phone Number: (_____) –_____–_____ Last Seen: _____

Psychopharm Prescriber: _____
Practice Name: _____ Location: _____
Phone Number: (_____) –_____–_____ Last Seen: _____

Primary Care Provider: _____
Practice Name: _____ Location: _____
Phone Number: (_____) –_____–_____ Last Seen: _____

Other Healthcare Provider: _____
Practice Name: _____ Location: _____
Phone Number: (_____) –_____–_____ Last Seen: _____

Hospital Contact: _____
Hospital Name: _____ Location: _____
Phone Number: (_____) –_____–_____ Last Seen: _____

Facility Contact: _____
Facility Name: _____ Location: _____
Phone Number: (_____) –_____–_____ Last Seen: _____

Probation Officer:_____
Court House: _____ Location: _____
Phone Number: (_____) –_____–_____ Last Seen: _____

State Worker Contact: _____
State Department: _____ Location: _____
Phone Number: (_____) –_____–_____ Last Seen: _____

Signature: _____**Date**: _____