

BridgePoint Health, LLC
Adult Intake Form

Please complete the following questionnaire. This information is confidential and will be used by your doctor or therapist to assist with your evaluation. This information can not be released to anyone, including your employer or any family member, without your written consent.

Name: _____ **Age:** _____ **Date of Birth:** _____

Sex: Male Female **Name of Primary Care Physician:** _____

Who referred you for this evaluation: Self Referred Physician EAP Friend
Family Court Other _____

Marital Status: Never Married Married Separated Widowed
Divorced Divorced and Remarried Widowed and Remarried

How many children do you have? _____ **Age Groups:** 0-1 2-4 5-8 9-12 13-17 18+

Ethnicity: Black, not of Hispanic origin Hispanic American or Alaskan Indian
Asian or Pacific Islander White, Not of Hispanic origin

Religion: Protestant Catholic Jewish None Other

Education: Grade 6 or less Grade 7 to 12 Graduated High School or Equivalent
Some College Graduated 2-yr College Graduated 4-yr College
Other: _____

Which best describes your current employment or working situation:

Skilled Laborer Homemaker Unskilled Laborer Professional Unemployed
Disabled Retired

How long have you been in this current job or work situation:

Less than 6 mnths Less than 1 yr Less than 2 yrs Less than 5 yrs More than 5 yrs

Were you ever in the military: Yes No

If yes, did you suffer any medical or mental illness? Yes No

How long has it been since your last physical or medical exam:

Less than 6 months Less than 1 yr Less than 2 yrs Less than 5 yrs More than 5 yrs

Do you use tobacco: Yes No If yes, what is your daily use? _____

Do you use caffeine (coffee, soda): Yes No If yes, what is your daily use? _____

Please complete the following information regarding prescription and nonprescription medications you are currently taking

Name of Medication	Dosage	How Often	For How Long	For What Condition

Are you allergic to any medications: Yes No If yes, which medication: _____

Symptoms you are experiencing for which you are seeking treatment:

Depression Anxiety or Panic Substance Abuse Worry Eating Problems Anger
 Stress Behavior Memory Problems Hearing or Seeing Things Thought Problems
 Other: _____

Duration of these above symptoms:

Less than 1 month Less than 3 months Less than 6 months Less than 1 year
 Less than 2 years More than 2 years

Is this something new or a return of something you had before: New Not New

Which of the following factors may be contributing to the reason you are seeking help:

Marital Relationship Financial Sexual Housing Frequent Moves Family
 Legal School Work Religious Health Death Alcohol/Drugs Children
 Recreation Boredom Injury Diet Traumatic Event Other _____

Have you ever had a prior evaluation or treatment by a mental health professional:

Yes or No If yes, please indicate when: _____

Type of professional(s) you saw: _____

Have you ever been hospitalized for this problem: Yes No

Have any family members been treated for an emotional and/or psychological problem:

Yes No If yes, please indicate member: Mother Father Sister Brother Grandparent

Please indicate the type of problem(s) the family member(s) experience: _____

BridgePoint Health, LLC
Medical Form

	YES	NO
Are you under a physician's care? For what reason?		
Have you ever had a serious illness or operation? If so, please explain:		
Do you have any allergies?		
Are you allergic to any medications or substances?		
Do you have any problems with penicillin, antibiotics, or anesthetics?		
Have you ever been treated for or been told you might have heart disease?		
Are you aware of any heart murmurs?		
Have you ever had rheumatic fever?		
Have you ever had surgery, radiation treatment, or chemo treatment for a tumor, growth, or other condition?		
Do you have high blood pressure?		
Do you have inflammatory diseases, such as arthritis or rheumatism?		
Do you have any artificial joints, prosthesis?		
Do you have any blood disorders, such as anemia, leukemia, etc?		
Have you ever bled excessively after being cut or injured?		
Do you have any stomach problems?		
Are you diabetic?		
Do you have asthma?		
Do you have epilepsy or seizure disorder?		
Do you have or have you had a venereal disease?		
Do you have HIV or AIDS?		
Have you ever had hepatitis?		
Do you or have you had TB?		
Are you pregnant or suspect that you may be?		
Do you have any other medical conditions that are not listed? Please list:		

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patient or Legal Guardian Signature

Date