Durango NVC Services

Patient Intake Form

Date:_____

Patient's Name: _____

Date of Birth: _____ Sex: M ☐ F ☐

Address: _____

Home Phone: _____ Cell Phone:_____

Work Phone:_____ (OK to call Work?) Yes ☐ No ☐

E-mail: _____

Are you: Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Name of spouse or partner:_____ Phone:_____

Name and ages of children (if adult)_____

Name and ages of siblings (if child)_____

Name of Emergency Contact:_____ Relationship to Patient:_____

Address:_____ Phone:_____

Guardian's Name:_____ Phone:_____

Referral Source:_____

_____

Edit Aquarian, NLC ~ Marriage and Family Therapist, Mediator, Life coach, Durango NVC Services, 808-214-3214
970.426.1684 (office) 1.970.797.1544 (fax) ~ PuraVida ~160 E. 12th Street, Suite 1, Durango, CO 81301

Health Information

Please answer the following questions using: 5 – Excellent, 4 – Good, 3 – Average, 2 – Poor, 1 - Failing

How would you currently rate your physical health? _____

How would you currently rate your mental health? _____

How would you currently rate your spiritual health? _____
(If this does not apply to you, please use N/A)

How committed are you to whole health wellness? _____

Please list current symptoms and describe why you are here. _____

_____

List briefly the top three things you would like to work on (please feel free to list more if necessary)

1. _____

2. _____

3. _____

Your goal for our sessions _____

Medical Information

Do you now have, or have you had in the past, any of the following? Check all that apply:Y/N

Asthma _____ Abortion (#) _____ Multiple Sclerosis _____ Hearing Problems _____

Brain Injury _____ Serious Accident _____ Pregnancy (#) _____ Tuberculosis _____

Digestive Disorders _____ Allergies _____ Sexually Transmitted Disease _____

Chronic Fatigue Syndrome _____ Breathing Problems _____ Epilepsy or Seizures _____

Surgery _____ Miscarriage (#) _____ High Blood Pressure _____ Cancer _____

Headaches _____ Sleep Disorder _____ Arthritis _____ Immune System Problems _____

Eating Disorder _____ Thyroid Disorder _____ Vision Problems _____ Diabetes _____

Fibromyalgia _____ Urinary Disorders _____ Heart Disease _____ PTSD/TBI _____

Are you currently under the care of a Doctor or other medical health professional? Yes □ No □

Name of Primary Care Physician: _____ Phone #: _____

Address: _____

Name of Specialist Physician: _____ Phone #: _____

Please list any prescription medications you are currently taking: _____

Please list any over the counter medications, vitamins, or herbal supplements you are currently taking:

_____

Do you currently exercise? If yes, please indicate how many times per week: _____

Substance Use

Please indicate substances currently used (over the last 6 months):

Substance Use	Currently?	Amount	Frequency	Age of first use	Length of Time Used
Caffeine					
Alcohol					
Tobacco					
Marijuana					
Ecstasy					
Cocaine/Crack					
Heroin					
Methampheta mines					
PCP/LSD/ Mushrooms					
Pain Killers					
Steroids					

Substance Use	Currently?	Amount	Frequency	Age of first use	Length of Time Used
Tranquilizers					
Sleeping Pills					
Diet Pills					
Other					

Have you ever believed your substance use was a problem for you? Yes ☐ No ☐

If answered YES, How? _____

_____

Has anyone ever told you they believed your substance use was a problem? Yes ☐ No☐

If yes, what was your reaction? _____

_____

Family Information

Were you adopted? Yes ☐ No ☐ If yes, age at time of adoption: _____

Did your parents ever divorce? Yes ☐ No ☐ If yes, age at time of divorce: _____

Were you ever in foster care or residential care? Yes ☐ No ☐

If yes, please list age and living situation: _____

_____

Have you ever experienced the death of a family member or close friend? Yes ☐ No ☐

Was that a traumatic even for you? Yes ☐ No ☐ If yes, please explain briefly: _____

_____

_____

_____

Please indicate if you or a member of your immediate family experienced any of the following. If a family member, please indicate relationship(s):

Event	Self	Other	Relationship	Event	Self	Other	Relationship
Emotional Abuse				Legal Problems			
Physical Abuse				PTSD/TBI			
Domestic Abuse				Financial Problems			
Sexual Abuse				Homelessness			
Neglect				Lived over-seas			
Substance Abuse				Frequent/ Multiple Move			
Serious Illness				Discrimination			
Accident / Injury				Depression			

Legal Information

Have you ever been a victim of a crime? Yes ☐ No ☐

Are you currently involved in a divorce or child custody proceeding? Yes ☐ No ☐

Have you ever been convicted of a misdemeanor or felony? Yes ☐ No ☐

Have you ever been incarcerated? Yes ☐ No ☐ If Yes, when and for how long? _____

What were you convicted of? _____

Mental/Emotional Health Information

Have you ever been in therapy before? Yes ☐ No ☐ Did you find it helpful or effective? Yes ☐ No☐

Did you find it helpful or effective? Yes ☐ No ☐ Why or why not? _____

_____

Do you suffer from: Mood Swings Yes ☐ No ☐ Excessive Anger Yes ☐ No ☐ Anxiety Yes ☐ No ☐

Excessive Fears Yes ☐ No ☐ Disordered Eating Yes ☐ No ☐ Hallucinations Yes ☐ No ☐

Have you ever been hospitalized for mental health concerns? Yes ☐ No ☐ If yes, when, where and for how long? _____

Have you ever been diagnosed with a mental health illness? Yes ☐ No ☐

If yes, what was the diagnosis? _____

Has anyone in your family been diagnosed with a mental illness? Yes ☐ No ☐

If yes, please list relationship and diagnosis _____

Have you ever or are you currently engaging in self harm? Currently ☐ Past ☐ No ☐

Have you ever or are you currently contemplating suicide? Currently ☐ Past ☐ No ☐

Have you ever or are you currently contemplating hurting another person? Currently ☐ Past ☐ No ☐

Have you ever attempted suicide? Yes ☐ No ☐ If yes, when and how many times? _____

_____

Has anyone in your family ever attempted suicide? Yes ☐ No ☐ If yes, what is your relationship to the person? _____

Has anyone close to you in your life ever attempted suicide? Yes ☐ No ☐

Additional information: _____

_____

Patient's Name (Print) _____

Patient's Signature _____

Guardian's Name (Print) _____

Guardian's Signature _____
(if patient is a minor or incapable of signing)

Date _____