



861 Manhattan Avenue  
Brooklyn, New York 11222  
[www.greenpointpsych.com](http://www.greenpointpsych.com)  
Tel: 718-383-3493  
Fax: 718-349-3939

Date Submitted \_\_\_\_\_

### **Intake Form**

(For patients with scheduled appointments)

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

S.S. #: \_\_\_\_\_ Gender: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ E-mail: \_\_\_\_\_

Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

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

City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Marital Status:    Single    Married    Living w/partner    Separated    Divorced    Widowed

List the people you live with and their relationship to you:

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

Are you currently    Employed full time    Employed part time    Not working

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

Employer: \_\_\_\_\_

List the problem(s) for which you seek help:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**I. INSURANCE INFORMATION**

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

I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

Contact Phone # on back of Insurance Card: \_\_\_\_\_

Name of Insured (Policy Holder): \_\_\_\_\_

Address of Insured: \_\_\_\_\_

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

**II. PSYCHIATRIC HISTORY**

Do you have mental health problems for which you've been treated?    Yes    No

If yes, complete the following:

<u>Diagnosis</u>	<u>Dates of Treatment</u>	<u>Name of Practitioner</u>
1. _____		
2. _____		

Have you ever been hospitalized for a mental health problem?    Yes    No

If yes, please complete the following for the two most recent hospitalizations:

<u>Diagnosis</u>	<u>Dates of Treatment</u>	<u>Name/Location of Hospital</u>
1. _____		
2. _____		

Are you presently receiving psychiatric help?    Yes    No

If yes:

Date started: \_\_\_\_\_

Type of treatment/frequency: \_\_\_\_\_

Name of practitioner/address: \_\_\_\_\_

**If you've taken any of the following medications, please indicate:**

	<u>Dates</u>	<u>Dosage</u>	<u>Helpful</u> (Yes or No)
Prozac (fluoxetine)			
Zoloft (sertraline)			
Luvox (fluvoxamine)			
Paxil (paroxetine)			
Celexa (citalopram)			
Lexapro (escitalopram)			
Effexor (venlafaxine)			
Cymbalta (duloxetine)			
Wellbutrin (bupropion)			
Desyrel (trazodone)			
Remeron (mirtazapine)			
Serzone (nefazodone)			
Lithium			
Lamictal (lamotrigine)			
Seroquel (quetiapine)			
Zyprexa (olanzepine)			
Abilify (aripiprazole)			
Clozaril (clozapine)			
Haldol (haloperidol)			
Xanax (alprazolam)			
Ativan (lorazepam)			
Klonopin (clonazepam)			
Valium (diazepam)			
Ambien (zolpidem)			
Buspar (buspirone)			
Adderall (amphetamine)			
Ritalin or Concerta (methylphenidate)			
Other _____			
Other _____			



**Medical Screening:**

Place a check next to any condition you have.

If you once had a condition but no longer do, provide the dates you had it.

If there's a family history of an illness, place an F next to that illness.

Headaches/Migraines

High Blood Pressure

Arthritis

Cancer

Epilepsy or seizures

Diabetes

Asthma/respiratory problems

Heart Disease

High Cholesterol

Sexually Transmitted Disease

Tuberculosis

Emphysema

Stomach or intestinal problems

Liver Disease

Chronic Pain

Kidney Disease

Other \_\_\_\_\_

Other \_\_\_\_\_

**Substance Use:**

Have you been treated for alcohol or drug abuse? Yes No If yes, when ? \_\_\_\_\_

What substance(s) did you abuse? \_\_\_\_\_

What is the name and address of the agency/agencies where you received treatment?

1. \_\_\_\_\_

2. \_\_\_\_\_

**IV. SOCIAL HISTORY**

Where were you raised? \_\_\_\_\_

If you have siblings, list their gender(s) and current age(s): \_\_\_\_\_

At what age did you leave your childhood home? \_\_\_\_\_

What is the highest grade you completed? \_\_\_\_\_

List any degree(s) you've attained: \_\_\_\_\_

*Thank you for completing our intake form.*

*Please bring it with you to your 1st appointment.*

*If you need assistance, contact our office manager, Steven Steele, at 718-383-3493, Ext. 4.*