THREE ARMS,LMSW,PLLC INTAKE FORM

Date:_____ Referral Source:_____
Name:_____
Address:_____
_____
_____

Email: _____

Home Phone Number:_____
Cell Number:_____
Emergency Contact & Phone:_____

Age:_____
Reason for Visit:_____
_____

HEALTH/MENTAL HEALTH CONDITIONS:
Any allergies?_____
What other health or mental health professionals are you presently seeing?
_____
_____
_____
Pregnant? Yes/No Trying to get pregnant? Yes/No

Do you have any medical or mental health diagnoses? Please list, date of onset of symptoms and date of diagnosis.
_____
_____
_____
_____
_____
Prescription medications you are currently taking and for what condition:
_____
_____
_____
_____
Herbs, vitamins, homeopathic remedies you are currently taking:
_____
_____
_____
_____
List surgeries/operations you think I should be aware of:
_____
_____
_____
_____
Date of your last physical examination _____ By whom?
_____

HEART:
Do you have a heart condition? Is so, describe

_____

_____.
Do you have an implanted pace maker?_____
Do you have any condition that **should not** be exposed to magnets? If so describe.

_____
_____
_____

SLEEP:
□ Restful and good □ Trouble falling asleep □ Trouble staying asleep
□ Excess dreaming □ Watch TV before bed Avg.hrs. slept each night?___
Do you work nights and sleep days? □ No □Yes What time do you go to sleep?____
Describe your sleeping patterns?

_____
_____
_____
If you awake in the middle of the night, what do you do to fall asleep again?

_____
_____
_____
Medications to help you sleep? Please list meds and how often you take them:

_____
_____
What electronic equipment do you have in your bedroom and how close to your bed is each device?

_____
_____
_____
_____

RELAXATION:
How do you like to relax or unwind?

_____
_____
_____
_____
Do you meditate, do yoga or any other similar discipline? If so, how often?

_____
_____
_____
_____
Do you drink alcohol or use recreational drugs? How often? Any abuse issues?

_____
_____
_____