Harriet Kohen, MSW, LICSW, CPT
Partners in Healing of Minneapolis • 10505 Wayzata Boulevard, #200
Minnetonka, MN 55305 • 763.546.5797

Intake Form

Today's Date: ________

Name (First) (M.I.) (Last)	**Birthdate:**	**Age:**	**Sex** **M F**
Work Phone: **Home Phone/Mobile:**	**Partner's Work Phone:** **Home Phone/Mobile:**		
Age: Occupation:	**Education Level**		
Legal Guardian (if applicable): **You currently live with:**			

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Name of person completing form____

Please give a brief description of why you are seeking treatment:

____
____
____
____
____
____
____
____

Who referred you to me / our clinic?____

1. FAMILY AND SOCIAL HISTORY

Family Members:	Age	Sex	At home?	Health Problem/Illness?	Adopted?

Please list anyone else living in the household? (Name, age, relationship)

____
____

If applicable, please give date(s) of marriage, separation(s) and/or divorce:

____
____

Comments about custody/visitation (if applicable)

____
____

Please describe any family history of mental health and/or chemical dependency problems or treatment:

____

____

Please note any involvement with social services, child protection, the court system or legal services:

____

____

Do you believe that you have ever been hurt as noted below? Yes No If yes, please circle:

Physically Emotionally Sexually By ways of neglect

Have you teenager ever witnessed physical violence? Yes No If Yes, please describe:

____

What major stresses or changes have occurred in your life?

____

____

____

Who do you regard as the most supportive people in your life:

____

____

Educational History

Name of current school:
____Year:________

Extracurricular Activities

____

____

Are you employed outside of the home? Yes ___ No ___ How many hours per week? __

Where:____

DEVELOPMENTAL HISTORY

Were there any problems during pregnancy, labor, birth or delivery with you?

Yes No

If yes, please give details:

____

____

Do you use any drugs, alcohol or nicotine? Yes No If yes please note details:

____

____

Do you have any physical disabilities or handicapping conditions?

Area	Yes	No	Describe:
1. Speech and Language	Yes	No	_________________________________
2. Hearing	Yes	No	_________________________________
3. Vision	Yes	No	_________________________________
4. Fine Motor Skills (writing)	Yes	No	_________________________________
5. Gross Motor Skills (walking)	Yes	No	_________________________________

Comments?____

____

MEDICAL HISTORY

Primary Care Physician:______________________________ **Name of Clinic**_______________

Date of last medical examination: _____________________________

Please list any current or ongoing medical problems:

____

____

Please note any hospitalizations (reason, dates, current status)

____

____

Please note any recent injuries (fractures, sprains, concussions) and current status:____

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Please note any history of surgery (operations) including reason, date(s), location (hospital, surgical center, city) and outcome (current status)

____
____

Please list any medication(s) currently taking, reason for medication , current dose, and name of prescribing physician:

Please list any previous medication(s) taken for psychological reasons, whether or not they were helpful, when and why they were discontinued.

____
____
____
____

Please note any drug allergies (name of medication, type of allergic/negative reaction)

____
____

Please note any other allergies and any medication taken for allergies

____
____

Have you had any pregnancies, miscarriages, abortions? Yes No If Yes please explain:

____
____

Does you use any over-the-counter medications regularly/frequently? Yes No

If Yes please note:

____
____
____

Does you have any communicable diseases? (such as Tuberculosis, Hepatitis, Sexually Transmitted Diseases "STD's") Yes No If yes, please note type, date, any treatment:

____
____
____

Please add any other medical history not noted above: (Use additional pages as needed)

____
____
____
____
____
____

CHEMICAL USE HISTORY

Are you concerned about your use of drugs or alcohol? Yes No If yes, please check all that apply:

Alcohol __________Comments?____
Amphetamines ("Speed")______Comments?__________________ ______________________
Tranquilizers_______ Comments? ____
Narcotics_______ Comments?____
Marijuana_______ Comments?____
Other___________
Do you use tobacco products? Yes No If yes, indicate if cigarettes, cigars, pipe chewing tobacco and estimated quantity per day? ___________________________________

Do you use caffeine? Yes No If yes, type?_____________________ Quantity per day?
____
____

Please note any therapists/counselors seen at present or in the past, including approximate dates and reason(s) for visits:
____
____
____
____

Please list dates and location of any psychiatric hospitalizations:
____
____
____

ADDITIONAL HISTORY

What are your favorite activities?
____
____

What are your greatest strengths?
____
____
____
____
____
____

What are you best at?
____
____
____
____

Is spirituality and/or faith system important to you?

____

In your family?

____

____

Please note any other hobbies, sports, clubs, or other activities that you are involved in:

____

____

____

Please add anything else you would like us to know: (Use additional sheets as needed.)

____

____

____

____

Signature__________________________

Thank-you for completing this form!