925 Ygnacio Valley Road, Ste 205, Walnut Creek, CA 94596. Phone (925) 289-9022 Fax (888) 965-0556

www.CalCBH.com

Intake Questionnaire

Patient information

Full Name_____DOB_____SSN_____

Address:_____City:_____Zip Code_____

Phone: Cell_____ Home _____

Email: _____

Insurance: _____ Insurance Phone _____

Insurance ID: _____ Group #: _____

Primary Insured Name: _____ DOB _____

Address_____ City: _____ State _____ Zip _____

Emergency Contact:

Name _____ Relationship _____

Cell Phone _____ Home Phone _____

Primary Care Doctor: _____Phone _____

Therapist/Psychologist: _____Phone: _____

Symptoms/Reason for visit:

_____

_____

_____

_____

_____

_____

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Previous Psychiatric Medications.

Medication	Dates	Dose	Effect

Are you in therapy or did you ever have therapy in the past. If yes, please describe.

_____

Any psychiatric hospitalizations? If yes, please list reason, dates and hospital.

_____

_____

Current Medical problems/Diagnoses: _____

_____

Are you pregnant (Yes/No). Do you plan pregnancy in the next year (Yes/No) Breastfeeding (Yes/No)

Are you using contraception (Yes/No) What method of contraception? _____

Current medications

Medication Name	Dose	Diagnosis	Duration

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Medications Allergies: (None) list allergies and reaction. _____
_____
_____

Habits: Current or in the past

	How much	How often	When	Problems caused by use.
Alcohol				
Tobacco				
Drugs List Names				
Marijuana				
Caffeine				

Anyone in your family have a history of depression, anxiety, bipolar disorder, schizophrenia etc.?
_____
_____
_____

Personal History: Where were you raised _____. Both parents or mother/father only.

Highest Education Level _____ Ages of siblings _____

Marital Status Single ____ Cohabitating ____Married____ Divorced ____Separated____Widowed____

Name of Significant Other: _____ Ages of children _____

Occupation _____ Years at job _____

Any problems at work/school _____Have you been arrested? _____