Mind Flex LLC
115 Pheasant Run Suite 212
Newtown Pa, 18940

ADULT INTAKE

ALL INFORMATION IS CONFIDENTIAL

GENERAL INFORMATION

Date: _____ Referred by: _____

Reason for Referral: _____

PATIENT INFORMATION

Patient Name _____ Date of Birth ____/____/____ Age _____

Sex: Male _____ Female _____

Ethnicity: Caucasian ____ African American ____ Hispanic ____ Other _____

Address _____

_____, _____ _____
(c*ity)* *(state)* *(zip code)*

Home phone (_____)_____ Work phone (_____)_____ ext. _____

Email _____ Fax (_____)_____ Other_____

Employer Name _____ Occupation _____

Employer Address _____
(*street)* *(city, state, zip code)*

Length of Employment _____ Hours worked per week _____

Marital Status: Single _____ Married _____ Separated _____ Divorced ____ Widow(er) _____

SPOUSE/PARTNER INFORMATION

Name _____ Date of Birth ____/____/____ Age _____

Mobile phone#_____ Work phone# (_____)_____ ext. _____

EMERGENCY CONTACT INFORMATION

In emergency contact: _____ Phone (_____) _____

MEDICAL HEALTH INSURANCE INFORMATION

Primary Insurance Carrier _____

Insurance Phone (_____)_____ Mental Health Phone (_____)_____

Subscriber Name _____ Date of Birth ____/____/____

Subscriber's Employer _____ Social Security # _____

Policy # _____ Group # _____

MEDICAL CARE INFORMATION

HEALTH CARE PROVIDER

Primary Care Physician_____
Physician Name_____

Address _____

_____, _____ _____
(city) *(state)* *(zip code)*

Office phone (_____)_____ **Office fax (_____)_____**

PREVIOUS TREATMENT HISTORY

Have you been diagnosed with any medical/physical/emotional/psychological conditions. If so, what diagnoses, when, and by whom?

_____

_____

_____

_____

MEDICAL TREATMENT (previous accidents, surgeries, or hospitalization, recurrent illness)

Description, condition	**Date**
_____	_____
_____	_____
_____	_____

PSYCHOLOGICAL TREATMENT (psychologist, counselor, social worker, family therapist)

Description, condition	**Date**

MEDICATION

Please list all medications, nutritional supplements taken including allergy shots, inhalers, vitamins/minerals, herbs. Please note any side effects, bad reactions or no effect for these drugs, etc.

	For Condition	**Dose**	**Dates of Usage**

Substance	**Current Frequency/Amount**	**Past Frequency/Amount**
Alcohol		
Cigarettes		
Cola		
Caffeine		
Marijuana		
Cocaine/Stimulants		
Hallucinogens		
Pain Killers		
Tranquilizers		
Sedatives		
Other _____		

FAMILY BACKGROUND

Mother Name _____ Date of Birth ___/___/___ Age _____

Occupation _____

Father Name _____ Date of Birth ___/___/___ Age _____

Occupation _____

Children (Please list names and ages of your own children)

_____

_____

_____

EDUCATIONAL HISTORY

Please list the schools you have attended, dates attended, degrees/certificates earned, etc.

_____

_____

_____

EMPLOYMENT HISTORY

Please briefly describe your current and past employment/work situations.

_____

_____

_____

What are the Primary Presenting Symptoms? (Why are you seeking treatment?)

_____

_____

What are your goals for treatment?

Any additional comments?