Bassi Psychological Services, Inc.

New Patient Intake Form

Name: _____ Today's Date:_____

Address:_____ Date of Birth:_____

_____ Email:_____
Ok to email: Y___ N___

Phone: CELL:_____ HOME:_____
Ok to leave messages: Y__N__ Ok to leave messages: Y__ N__

Occupation:_____

Relationship Status: _____

Emergency Contact:_____
Name, Relation, Phone Number
-By providing this information you are authorizing therapist to contact this person in the case of an emergency-

Others living in your home (Name, Age, Relation):_____
_____
_____

Primary Care Physician:_____
Phone:_____ Fax:_____

Primary Insurance Information: all fields are required in order for therapist to bill your insurance

Insured Name:_____ Insured SSN: _____

Insured DOB:_____ Member #:_____

Name of Insurance:_____ Provider Phone #:_____
Relationship to the Primary Insured: _____(ex: spouse, child, etc…)

Please describe your reasons for seeking treatment:_____

_____

When did the issue arise, was there an event that made these issues surface: _____

_____

What do you expect from therapy:_____

_____

Please indicate and rate the issues you would like to work on in treatment:

1-Not an Issue 2-Mild Issue 3-Moderate Issue 4-Severe Issue

__Depression
__Anxiety
__Controlling Stress
__Loss of Loved One
__Problems at School
__Problems at Work
__Other_____

__ Lack of Friends
__ Loneliness
__Problems Coping
__Abuse
__Financial Problems
__Legal Matter:

__Relationship Issues
__Sexuality/Sexual Issues
__Family Conflict
__Behavioral Problems
__Drugs/Alcohol
__Other Maladaptive

Personal Medical History

Allergies (including food/medication):_____

Current Medications:_____
_____

Past Hospitalizations/Surgeries/Major Medical Issues:_____

_____

_____

Date of Last Physical and Findings:_____
_____

Are you currently being treated for medical issues:_____
_____

LIFESTYLE/HABITS

	Amount Currently Using	Most Ever Used	When
Coffee (cups/day)	_____	_____	_____
Other Caffiene	_____	_____	_____
Cigarettes/Vaping	_____	_____	_____
Alcohol	_____	_____	_____
Drugs	_____	_____	_____

	Type(s)	Frequency
Current Exercise	_____	_____
Current Hobbies	_____	_____
Hrs/week at work	_____	

Do you have a history of blackouts, seizures, or withdrawals? (If yes, describe):

_____

_____

Have you ever received mental health/substance abuse treatment before?

_____

_____

Family Medical History

Has anyone in your family had a serious medical illness-please explain:_____

_____

Has anyone in your family had a mental health issue or mental illness:_____

_____

Has anyone in your family had a substance abuse issue:_____

_____

INFORMED CONSENT REGARDING PROVIDERS

This is intended to clarify the relationships of the providers in this office. The provider you are being treated by is, _____. Although the providers in this office share space, they are not partners, nor otherwise affiliated. Each provider in the office is independently licensed, carries their own business license, and do not practice together. **They are not responsible for one another's practice or clients.**

_____The above has been explained to me by my therapist.

_____ _____

Print Name Date

_____

Signature