Name: DOB: Date: Title 19:

Optimae Behavioral Health

Customer Intake Form

Please answer the questions that you feel comfortable sharing. You do not have to answer all questions, as there may be some that you wish to address privately with your therapist.

Presenting Concerns

1. Please briefly describe why you are coming in today.

2. Please briefly share what you want to gain from therapy services.

Treatment History

1. Have you ever received counseling services in the past? **Yes** **No**
   Please list previous treatment provider(s), location(s), and approximates dates of counseling below:
   If yes, how would you rate your response to counseling services? ***Excellent*** ***Good*** ***Fair*** ***Poor***

2. Have you ever received substance abuse treatment? **Yes** **No**
   Please include any history of gambling and gaming even if no treatment provided.
   Please list provider, location, and duration of treatment below:
   If yes, how would you rate your response to substance abuse treatment? ***Excellent*** ***Good*** ***Fair*** ***Poor***

3. Have you ever received services through a psychiatrist? **Yes** **No**
   Please list previous psychiatrist(s), location(s), and approximate dates of psychiatric services below:
   If yes, how would you rate your response to psychiatric treatment? ***Excellent*** ***Good*** ***Fair*** ***Poor***

4. Have you ever received treatment in an inpatient setting? **Yes** **No**
   Please list hospital(s), location(s), and approximate date of hospitalization(s) below:
   If yes, how would you rate your response to inpatient treatment? ***Excellent*** ***Good*** ***Fair*** ***Poor***

5. Describe your response to psychiatric medication(s). ***Excellent*** ***Good*** ***Fair*** ***Poor*** ***N/A***

6. Do you have a primary care physician? **Yes** **No**
   Name of PCP:
7. Are you being treated for any medical conditions? **Yes** **No**
   Please list current medical conditions:

8. Do you receive any other type of alternative, holistic, or natural care? **Yes** **No**

9. *Please note how much caffeine you consume daily* _____

10. *Please note how many cigarettes you smoke daily* _____

Demographic/Background Information:

1. Please provide your marital status ***Single*** ***Married*** ***Divorced*** ***Separated*** ***Widowed***

2. What is the highest level of education you have completed?
K-6 ***7-12*** ***GED*** ***some college*** ***AA Degree*** ***BA Degree*** ***MA Degree*** ***Doctorate Degree***

3. Are you currently employed? **Yes** **No**

4. Are you currently receiving social security benefits? **Yes** **No**

5. Do you have a Care Coordinator/Case Manager/Worker **Yes** **No**

   If yes, please note the services you are receiving:

6. Do you have a representative payee? **Yes** **No**

7. Do you have specific cultural, religious, of Church affiliations? **Yes** **No**
   Please List:

8. Do you have a court appointed guardian? **Yes** **No**
   Name of Guardian:

9. Are you on Probation? **Yes** **No**
   PO Name:

10. Do you have an Attorney, Legal Advocate, or Judicial Referee **Yes** **No**
    Attorney Name:
    Legal Advocate:
    Judicial Referee:
    Past Legal History:

11. Do you have a county commitment? **Yes** **No**

_____

Client Signature and Date