Pinnacle Behavioral Health
Pinnacle Psychology Associates

In-Take Registration

SECTION 1: Demographic & Background Information

Client's Name _____Date _____

Telephone: Home_____ Work _____ Cell_____

**** If you do not want messages left on any of these telephone numbers, please circle the number.***

Client's Email: _____

Address _____ City_____ State _____ Zip _____

Age _____ Date of Birth _____ Sex _____ Marital Status _____

Social Security # _____ Referred By _____

For Clients Under the Age of 18:

Father's Name _____ Cell _____ Email _____

Mother's Name _____ Cell _____ Email _____

Primary Care Physician: Name _____ Telephone _____

Household Members & Children - please list all members of your household and include all children.

Name	**Age**	**Relationship**

What is your reason for seeking therapy at this point? _____

_____

_____

_____

_____

_____

Did anything or any life event seem trigger to set off this problem for you? □ Yes □ No

If yes, please describe what happened: ? _____

_____

_____

_____

Has anyone else been encouraging/pressuring/forcing you to seek help? □ Yes □ No

Have you participated in therapy before? □ Yes □ No

How many times? _____ What was the reason for seeking therapy in the past?

_____

_____

_____

Section 2: Partnership/Marital Relationship(s): ***Only* complete this section if you are over 18**

How many times have you lived with someone in a committed relationship or been married? _____

Currently, are you currently: □ single □ dating casually □ dating one person □ married

□ separated □ divorced □ living with a significant other _____

If married or living with a significant other, how long have you been together or married? _____

How well do you and your spouse/significant other get along? (circle the answer below)

Very Poorly	Not too well	Okay	Pretty Well	Very Well
Are you satisfied with your current spouse/partner?			□ Yes □ No	
Are you satisfied with your current relationship with your children?			□ Yes □ No	

What do you consider to be the purpose of marriage or your current relationship?

_____

_____

_____

_____

SECTION 3: Areas of Concern

Please check the symptoms below that are currently an issue **(C)** or have been an issue in the past **(P)**.

C	***P***		***C***	***P***		***C***	***P***		***C***	***P***	
☐	☐	addiction	☐	☐	disorientation	☐	☐	infidelity	☐	☐	phobia
☐	☐	aggression	☐	☐	disorganization	☐	☐	impulsivity	☐	☐	physical illness
☐	☐	alcohol use	☐	☐	domestic violence	☐	☐	irritability	☐	☐	pleasure loss
☐	☐	anger	☐	☐	drug use	☐	☐	irresponsibility	☐	☐	pornography
☐	☐	anorexia	☐	☐	easily distracted	☐	☐	jealousy	☐	☐	racing thoughts
☐	☐	appetite loss	☐	☐	fatigue	☐	☐	loneliness	☐	☐	recurring thoughts
☐	☐	avoiding people	☐	☐	fear	☐	☐	loss of control	☐	☐	restlessness
☐	☐	anxiety	☐	☐	gambling	☐	☐	low energy	☐	☐	sleeping problems
☐	☐	binge eating	☐	☐	guilt	☐	☐	low self esteem	☐	☐	sexual difficulties
☐	☐	chest pain	☐	☐	hair pulling	☐	☐	memory loss	☐	☐	social anxiety
☐	☐	confusion	☐	☐	hallucinations	☐	☐	mood instability	☐	☐	stealing
☐	☐	compulsions	☐	☐	headaches	☐	☐	nightmares	☐	☐	suicidal thoughts
☐	☐	crying	☐	☐	heart racing	☐	☐	obsessions	☐	☐	trauma
☐	☐	depression	☐	☐	hoarding	☐	☐	overwhelmed	☐	☐	trembling/shaking
☐	☐		☐	☐	hopelessness	☐	☐	panic attacks	☐	☐	worry
☐	☐		☐	☐	indecision	☐	☐	perfectionism	☐	☐	worthless feeling

*Additional information:*_____

_____

_____

_____

_____

_____

SECTION 4: Family History

Have any other members of your family experienced a psychiatric/emotional disorders? ☐ Yes ☐ No

If yes, please provide as much information as you know about the nature of the disorder, treatment and current status: _____

_____

_____

_____

_____

Regarding your mother: Current Age____ If deceased, how long ago did she die? _____

Occupation: _____ If retired, her previous occupation: _____

Regarding your father: Current Age____ If deceased, how long ago did he die? _____

Occupation: _____ If retired, her previous occupation: _____

How well did you parents get along with each other? (circle the answer below)

Very poorly	Not too well	Okay	Pretty well	Very well

Are your parents separated or divorced?	☐ Yes ☐ No
If divorced, has your **mother** remarried?	☐ Yes ☐ No
If divorced, has your **father** remarried?	☐ Yes ☐ No
Were you adopted or raised by parents other than your biological parents?	☐ Yes ☐ No
Did anything unusual happen to you while you were growing up?	☐ Yes ☐ No

Which members of your family are you close to and why? _____

_____

_____

Which members of your family were a source of hurt or pain to you and why? _____

_____

_____

_____

SECTION 5: Medical History

Medication Name	Dose	Purpose

When was your most recent physical exam?_____ Where any medical issues identified or discussed?

_____

_____

_____

List any major illnesses, injuries, and/or operations you have had: _____

_____

_____

_____

List any physical problems you are having at present: _____

_____

_____

_____

Do you smoke? (please circle)	□ Yes □ No
Do you exercise on a regular basis?	□ Yes □ No
On average, how many hours of sleep do you get per night?	_____
Do you have trouble falling asleep?	□ Yes □ No
Do you have trouble staying asleep?	□ Yes □ No
Do you wake up too early in the morning?	□ Yes □ No
Do you sleep *too much* or *not enough*? (please circle)	□ Yes □ No
Have you gained or lost weight recently?	□ Yes □ No
Was the weight loss/gain intentional?	□ Yes □ No
Do you eat a well balanced/nutritional diet?	□ Yes □ No
Do you eat *too much* or *not enough*? (please circle)	□ Yes □ No

SECTION 6: Substance Use:

Do you drink alcoholic beverages on a regular basis? Yes____ No____

If yes, what is your preferred beverage(s)? _____

How many drinks do you have per day _____ or per week _____ or per month? _____

Are you concerned about the way you drink alcohol? Yes____ No____

Is anyone close to you concerned about the way you drink alcohol? Yes____ No____

Do you take any recreational drugs besides alcohol on a regular basis? Yes____ No____

If yes, what recreational drugs do you take? _____

How often do you take recreational drugs? _____

Are you concerned about your use of recreational drugs? Yes____ No____

Is anyone close to you concerned about the way you use recreational drugs? Yes____ No_____

Does anyone in your family have a history of alcohol/drug abuse/dependence? Yes___ No____

If yes, what relationship does this person(s) have to you? _____

Do you smoke cigarettes? Yes____ No_____

If yes, how many packs do you smoke a day? _____

Do you drink caffeinated beverages? Yes____ No____

If yes, how many 12 ounce cups do you drink daily? Coffee____ Soda____

SECTION 7: Friendships:

On a scale of 1-10, with 10 being very out-going (extroverted) and 1 being very shy (introverted), where would you put yourself?

1	2	3	4	5	6	7	8	9	10

Do you have close friends?	□ Yes □ No
Do your friends live close by and do you see them on a regular basis?	□ Yes □ No
Are you satisfied with your current friendship status?	□ Yes □ No

Overall, how well do you get along with people outside your family? (circle the answer below)

Very Poorly	Not too well	Okay	Pretty Well	Very Well

***SECTION* 8: Education:**

Are you currently in school? Yes___ No___

If yes, what school are you attending? _____

What are you studying? _____

How many courses are you taking per quarter or semester? _____

What is your highest educational degree? High School____ Bachelors____ Masters____ Doctorate____

What is/was the name of the last college attend? _____

What was your major? _____

How well did you do or are you doing in school? Not so well___ Okay___ Good___ Excellently___

Are you satisfied with your educational achievement? Yes___ No___

***SECTION* 9: Employment:**

Where do you work? _____

What kind of work do you do? _____

What is the purpose of work? _____

How well do you function at work? Very poorly___ Not so well___ Okay___ Good___ Excellently___

Are you satisfied with your current employment status? Yes___ No___

***SECTION* 10: Spirituality:**

How important is spirituality/religion to you? _____

What religion were you raised in? _____

Are you currently a member of a religion? Yes___ No___ If yes, which one? _____

Are you satisfied with your current spiritual/religious practice? Yes___ No___

***SECTION* 11: Self Care:**

How important to you is time to yourself?_____

Do you get enough time daily to take care of yourself? Yes___ No___

What kind of leisure activities/hobbies do you enjoy? _____

How well are you managing your finances?

Very Poorly	Not So Well	Okay	Good	Excellent

How well are you handling routine chores e.g. laundry, cleaning, cooking?

Very Poorly	Not So Well	Okay	Good	Excellent

Are you satisfied with your self-care status? Yes____ No____

***SECTION* 12: Insurance Information:**

Name of Company _____ Policy Number _____

Primary Insured's Name _____ Group Number _____

Please read the following statements, check yes or no, and sign below:

□ Yes	I understand that I am responsible for all charges for services provided to me regardless of insurance reimbursement.
□ Yes	I agree to pay all fees owed by me at the time of my visit.
□ Yes	I agree to pay the full fee for appointments not cancelled 24 hours in advance.
□ Yes	I give Pinnacle Behavioral Health/Pinnacle Psychology Associates permission to release information obtained from me that is necessary to authorize treatment and obtain reimbursement from my insurance plan.
□ Yes	I assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to Pinnacle Behavioral Health/Pinnacle Psychology Associates.

Client's Signature: _____ Date: _____