BWTS Intake Form

Name: _____ Date:_____

DOB: _____ Gender & Sexual Identity: _____

Home Address: _____

Employment Status: ___ Full Time ___ Part Time ___ Student ___ Retired Other _____

Type of Employment/Name of School: _____

Highest Level Of Education: _____

Primary Phone Number: _____ Text Friendly: ___ Yes ___ No

Do you have any phone restrictions (don't leave messages, etc.)? Please describe:

Primary Email Address: _____

Preferred contact (Rank order): ___ Telephone ___ Text ___ Email

Emergency Contact (I will only contact this person in the event of a medical or behavioral health emergency)
Name:_____ Relationship: _____

Primary Telephone Number: _____

What is the reason you are seeking treatment now?

What are your goals for treatment?

BWTS Intake Form

Do you have a Primary Care Physician? ___ Yes ___ No

Name: _____ Telephone: _____

Do you have a Psychiatrist? ___ Yes ___ No

Do you need me to notify or coordinate with any other medical professional? Please explain:

Previous medical hospitalizations (Approximate dates and reasons):

Previous psychiatric hospitalizations (Approximate dates and reasons):

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? ___YES ___NO
(Please list approximate dates and reasons):

List any current Medications AND Supplements (if there is a long list feel free to attach a list):

Do you smoke or use tobacco? ___YES ___NO If YES, how much per day? _____

Do you consume caffeine? ___YES ___NO If YES, how much per day? _____

Do you drink alcohol? ___YES ___NO If YES, how much per day/week/month/year?_____

Do you use THC? ___YES ___NO If YES, how much per day? _____

Do you use any non-prescription drugs? ___YES ___NO If YES, what kinds and how often?

BWTS Intake Form

Are you or anyone else concerned about your substance use? ___YES ___NO

Have you ever been in trouble or in risky situations because of your substance use? ___YES ___NO

FAMILY:
How would you describe your family relationships?

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:
Currently in Relationship? How Long? _____Satisfaction?_____ Married/Life Partnered? _____
Previously Married/Life Partnered? ___YES ___NO
If so, length of previous marriages/committed partnerships

Do you have Children? If YES, how many and what are their ages:

Describe any problems any of your children are having: _____

List the names and ages of those living in your household: _____

Please briefly describe your coping mechanisms and self-care:_____

Is spirituality important in your life and if so please explain:

Briefly describe your diet and exercise patterns: