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INTAKE FORM

In order for me to best help you, please fill out the following information. All information is strictly confidential and cannot be legally released without your written permission. Please use the back of this page for additional, if necessary.

NAME _____ TODAY'S DATE _____
Last First Middle
ADDRESS_____
Street City State Zip
OCCUPATION _____HOME PHONE_____

EMPLOYED AT_____ WORK PHONE_____

EMAIL Address _____ CELL PHONE _____

Birth date _____ Birthplace _____

Marital Status: Single _____Married _____ Separated _____Divorced _____

Highest grade completed _____

REFERRED BY: Self _____ Doctor _____ Insurance Co. ____ Other _____

INSURANCE COMPANY _____ YOUR POLICY/GROUP# _____

INSURANCE COMPANY ADDRESS _____

INSURED'S NAME_____ INSURED'S BIRTHDATE _____

INSURED'S ID/POLICY NUMBER _____

SECONDARY INSURANCE _____ ID NUMBER_____

MAJOR REASON FOR SEEKING HELP AT THIS TIME _____

_____

_____

_____

PLEASE LIST PREVIOUS THERAPY, COUNSELING OR HOSPITALIZATIONS

YEAR THERAPIST LOCATION HOW LONG? RESULTS?

_____

_____

HOW LONG HAVE THESE THINGS BEEN BOTHERING YOU? _____

_____

WHAT HAVE YOU TRIED TO DO SO FAR? _____

_____

MEDICAL HISTORY

Date of last medical examination _____ last audiological examination _____

Any medications?_____ for what?_____

List serious illnesses, injuries, surgeries or hospitalizations and dates:

_____

_____

When was your hearing impairment first diagnosed?_____

Who diagnosed it? _____ Do you wear hearing aids? R ____L ___

Degree of hearing impairment i.e. db loss? R ____ L ____

What is the cause of your hearing loss (if known)?_____

Name and phone # of audiologist/ENT Dr. _____

FAMILY INFORMATION

NAME RELATIONSHIP AGE OCCUP WHERE LIVE HOW YOU GET ALONG?

_____

_____

_____

_____

_____

Put an * next to the name of anyone who has a history of mental illness, alcoholism, drug use or eating disorder.
Put two ** next to their name if it is current.

WHO DO YOU LIVE WITH NOW? RELATIONSHIP? HOW LONG?
_____

_____

What hobbies, interests or special skills do you have? _____

_____

PLEASE CHECK ALL THAT APPLY

____ Headaches
____ Loneliness
____ Worried
____ Depressed
____ Trouble concentrating
____ Trouble sleeping
____ Nightmares
____ Stomachache
____ Feeling hopeless
____ Panic Attacks
____ Weight change
____ Financial Hardship
____ Trouble with boss
____ Ready to Explode
____ Embarrassment about hearing loss
____ Easily frustrated
____ Drink Excessively
____ Feelings of Unreality
____ Obsessive Thoughts
____ Loss of Sexual Desire
____ Suicidal Feelings
____ Dizziness/numbness

Have you ever been hospitalized for mental health reasons?

Past suicide attempts? _____

If so, when and where? _____

PAST OR CURRENT USE OF DRUGS AND ALCOHOL (HOW OFTEN?)

	Past	Current
Alcohol	_____	
Marijuana	_____	
Cocaine	_____	
Cigarettes	_____	
Coffee	_____	
Other	_____	

Any other information that you think would be helpful for me to know? _____

_____

_____

Thank you for taking the time to answer this form.