IMS
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TREATMENT INTAKE FORM

PERSONAL INFORMATION

Name: _____

Address:
_____

_____

Phone: _____

Email: _____

Date: _____

DOB:_____

Sex:_____

SSN:_____

SERVICES REQUESTED

Why are you seeking services?_____

Date when the issue began:

_____

Have you previously suffered from this current issue?

_____

Previous therapist (s)_____

Previous treatment_____

Have you ever been arrested? _____

When and why? _____

Name of Current Probation Officer:_____

Phone number:_____

PRESENT SITUATION

☐ Full-time ☐ Part-time	☐ Student ☐ Unemployed	☐ Disable ☐ Retired	☐ _____ Other

MARITAL STATUS

☐ Single	☐ Married	☐ Divorce	☐ Partner	☐ Widow

Do you have Children? _____

How is the relationship with your child (ren)? _____

List anyone else who lives with you. _____

CURRENT SYMPTOMS

☐ Anxiety	☐ Appetite Issues	☐ Avoidance
☐ Depression	☐ Withdrawal	☐ Fatigue
☐ Hallucinations	☐ Impulsivity	☐ Irritability
☐ Loss of Interest	☐ Panic Attacks	☐ Racing thoughts
☐ Sleep Changes	☐ Risky Activity	☐ Cravings
☐ Using Substances	☐ Other_____	☐ Guilt

HEALTH HISTORY & CURRENT MEDICAL CONDITIONS(Check all that apply)

Do you have any Allergies? Yes _____ No _____ If yes please list them: _____ _____	Have you recently been hospitalized? Yes _____ No _____ If yes please list them: _____ _____
Do you have any Physical Restrictions? Yes _____ No _____ If yes please list them: _____ _____	Past serious medical condition/injuries? _____ Any current medication:_____ _____

HAVE YOU EVER USED THE FOLLOWINGS(Check all/if that apply)

☐ Alcohol	☐ Cocaine	☐ Methadone	☐ Methamphetamines
☐ Tobacco	☐ Heroin	☐ Oxycodone	☐ Hallucinogens
☐ Marijuana	☐ Ecstasy	☐ Suboxone	☐ Stimulants

DRUG AND ALCOHOL USE HISTORY(Check all that apply)

What is your drug of choice? _____ Date of first use? _____ Date of last use? _____ Length of use? _____ Amount used? _____	Have you ever been in treatment before? _____ _____ When and where? _____ _____ _____
Do you smoke cigarettes or use alcohol currently? _____ _____	What is your motivation to seek treatment at this time? _____
Have you ever used Suboxone? _____	If female, could you be pregnant? _____

MENTAL HEALTH HISTORY

Do you have a history of mental health needs?	___Yes ___No
Does anyone in your family have mental health needs?	___Yes ___No
Are you currently taking any medications for your mental health?	___Yes ___No
Have you ever been hospitalized for mental health?	___Yes ___No
Have you ever been in treatment before for your mental health?	___Yes ___No
Are you currently having any thoughts of hurting yourself or others?	___Yes ___No
Are you being treated anywhere else for mental health?	___Yes ___No
Are you seeking mental health services currently?	___Yes ___No
How long have your mental health symptoms been going on?	___Yes ___No

PRIMARY HEALTH PHYSICIAN AND THERAPY TREATMENT CARE INFORMATION (If that apply)

Primary Physician: _____

Current Therapist: _____ Yes _____No

Name:_____

Address: _____

Phone #: _____ Fax #: _____

Did someone refer you?

_____

OFFICE USE ONLY

IMS location @: _____Today's date and time: _____

Current attention code Y N / Note:_____ Received by:_____

Approved by: _____ Date: _____ Time :_____

Signed: _____

06152023