The Joy of Life Clinic
Revive. Thrive. Live Fully

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New Patient History and Intake Form

Please complete each section of this form as best as you can. Your information is confidential and will help us understand your needs, allowing us to create the best possible treatment plan for you.

Are you filling out this form for yourself or someone else?	☐ Myself	☐ Someone Else

PART 1: PATIENT'S BIOGRAPHICAL INFORMATION

Name:	FIRST:		MI:	LAST:
Maiden/Other Name(s):				
DOB (MM/DD/YYYY):			SS#:	
Race/Ethnicity:	☐ American Indian or Alaska Native		☐ Asian	
	☐ Black or African American		☐ White/Caucasian	
	☐ Hispanic or Latino			
	☐ Native Hawaiian or Other Pacific Islander			
	☐ Other		☐ Prefer not to answer	
Sex/Gender:	☐ Male	☐ Female	☐ Other	☐ Prefer not to answer

PART 2: PATIENT'S CONTACT INFORMATION

Street Address:				Apt:
City:		State:		ZIP:
Cellphone:		Home Phone:		Fax:
Email:				
How may we contact you?	☐ Cellphone	☐ Email	☐ Other	
Leave a message on your:	☐ Cellphone	☐ Home Phone	☐ Other	☐ Don't leave messages
Emergency Contact Person:			Relationship:	
Emergency Contact Person's Phone:			Email:	

PART 3: PROVIDERS/PHARMACY INFORMATION

Primary Care Provider (Please enter as much information as you have about your PCP)

Name of Your Primary Care Provider (PCP):			
Name of PCP's Clinic (If Applicable):			
PCP's Address:			Suite:
City:		State:	ZIP:
PCP's Phone:		Fax:	
PCP's Email (if you know it):			

Current/Previous Mental Healthcare Provider (Enter as much information as you have. Skip, if none)

Name of Mental Health Care Provider:			
Provider's Clinic (If Applicable):			
Provider's Address:			Suite:
City:		State:	ZIP:
Provider's Phone:		Fax:	
Provider's Email (if you know it):			

Current/Preferred Pharmacy (Enter as much information as you have. Skip, if none)

Name of Current/Preferred Pharmacy:			
Pharmacy's Address:			Suite:
City:		State:	ZIP:
Pharmacy's Phone:		Fax:	
Pharmacy's Email (if you know it):			

How did you hear about us? (If a provider, please include their name):

Additional information/instruction regarding your provider(s)/pharmacy(ies)

PART 4: INSURANCE/PAYMENT INFORMATION

I will pay by (check all that apply):	☐ Insurance	☐ Medicaid/Medicare	☐ Self-pay

Please be sure to complete the “Authorization to Bill Insurance” or the “Self-Pay Agreement Form.”

Insurance Information

(This information can be found either on the medical insurance/program card)

Name of Insurance Company/Program:			
Name of Primary Insured:		DOB:	
ID #:		Group #:	
Effective Date (if you know it):		Expiration Date:	
Insurance Company’s Address (if you know it):			
City:		State:	ZIP:
Phone:			

Additional Insurance Information (if any)

Name of Insurance Company/Program:			
Name of Primary Insured:		DOB:	
ID #:		Group #:	
Effective Date (if you know it):		Expiration Date:	
Insurance Company’s Address (if you know it):			
City:		State:	ZIP:
Phone:			

Additional information/instruction regarding your insurance/payment information

PART 5: HISTORY OF PRESENT ILLNESS

What is the primary reason for your visit?

Are you currently experiencing symptoms?	☐ Yes	☐ No

If “Yes,” indicate the symptoms (check all that apply):

☐ Aggression	☐ Gambling	☐ Physical trauma perpetrator
☐ Agitation	☐ Grief	☐ Physical trauma victim
☐ Anger	☐ Guilt	☐ Poor concentration
☐ Anxiety	☐ Hallucinations	☐ Poor grooming
☐ Appetite Change	☐ Hearing voices	☐ Racing thoughts
☐ Change in libido	☐ Heart palpitations	☐ Recurring thoughts
☐ Compulsions	☐ Hopelessness	☐ Self-mutilation
☐ Crying/tearful	☐ Hyperactivity	☐ Sexual addiction
☐ Cyber addiction	☐ Impulsivity	☐ Sexual difficulties
☐ Delusions	☐ Irritability	☐ Sexual trauma perpetrator
☐ Depression	☐ Judgment errors	☐ Sexual trauma victim
☐ Difficulty getting out of bed	☐ Loneliness	☐ Sleep problems
☐ Disorientation	☐ Loss of interest in activities	☐ Social isolation
☐ Eating disorder	☐ Memory impairment	☐ Speech problems
☐ Distractibility	☐ Mood swings	☐ Substance abuse
☐ Elevated mood	☐ Obsessions	☐ Suicidal thoughts
☐ Emotional trauma perpetrator	☐ Oppositional behavior	☐ Worried
☐ Emotional trauma victim	☐ Panic attacks	☐ Other:
☐ Excessive energy	☐ Paranoia	☐ Other:
☐ Fatigue	☐ Phobias/fears	☐ Other:

More about your present illness:

Do you have prior outpatient treatment?	☐ Yes	☐ No	☐ Decline to answer

If you answered “No” to the previous question, please ignore this line. If “Yes”, please specify the reason for your prior outpatient treatment (for psychiatric, emotional, or substance abuse disorder). Use the space below:

When did you START and STOP your outpatient treatment?	From:	To:

Who provided your outpatient treatment? Use the space below:

Would you like to add any additional details about prior outpatient treatment?	☐ Yes	☐ No

If “No”, please ignore this line. If “Yes”, please specify the reason for your prior outpatient treatment (for psychiatric, emotional, or substance abuse disorder). Use the space below:

When did you START and STOP this outpatient treatment?	From:	To:

Who provided your outpatient treatment? Use the space below:

Would you like to add any additional prior outpatient treatment details?	☐ Yes	☐ No

If “No”, please ignore this line. If “Yes”, please specify the reason for your prior outpatient treatment (for psychiatric, emotional, or substance abuse disorder). Use the space below:

When did you START and STOP this outpatient treatment?	From:	To:

Who provided your outpatient treatment? Use the space below:

More about your present illness:

Do you have prior inpatient treatment?	☐ Yes	☐ No	☐ Decline to answer

If you answered “No” to the previous question, please ignore this line. If “Yes”, please specify the reason for your prior inpatient treatment (for psychiatric, emotional, or substance abuse disorder). Use the space below:

What date did the hospitalization begin and end?	Start:	End:

Where did you get hospitalized?	

Would you like to add any additional prior inpatient treatment details?	☐ Yes	☐ No

If “No”, please ignore this line. If “Yes”, please specify the reason for your additional prior inpatient treatment (for psychiatric, emotional, or substance abuse disorder). Use the space below:

What date did this hospitalization begin and end?	Start:	End:

Where did you get this hospitalization?	

Would you like to add any additional details about prior inpatient treatment?	☐ Yes	☐ No

If “No”, please ignore this line. If “Yes”, please specify the reason for your additional prior inpatient treatment (for psychiatric, emotional, or substance abuse disorder). Use the space below:

What date did this hospitalization begin and end?	Start:	End:

Where did you get this hospitalization?	

Have you taken any psychiatric medications in the past?	☐ Yes	☐ No

If you answered “No” to having taken any psychiatric medications in the past, please ignore this line. If “Yes”, enter the name of one of your past psychiatric medications. Use the space below:

When did you start and stop taking this psychiatric medication?	Start:	End:

What was the dosage?	

Did this medication help?	☐ Yes	☐ No

Were there any side effects from this medication?	☐ Yes	☐ No

If “No” to the previous question, please ignore this line. If “Yes”, what were the side effects? Use the space below:

Would you like to add any additional past psychiatric medication details?	☐ Yes	☐ No

If “No”, please ignore this line. If “Yes”, enter your next psychiatric medication. Use the space below:

When did you start and stop taking this psychiatric medication?	Start:	End:

What was the dosage?	

Did this medication help?	☐ Yes	☐ No

Were there any side effects from this medication?	☐ Yes	☐ No

If “No”, please ignore this line. If “Yes”, what were the side effects of this medication? Use the space below:

Would you like to add any additional past psychiatric medication details?	☐ Yes	☐ No

If “No”, please ignore this line. If “Yes”, enter your next psychiatric medication. Use the space below:

When did you start and stop taking this psychiatric medication?	Start: ☐	End: ☐

What was the dosage?	

Did this medication help?	☐ Yes	☐ No

Were there any side effects from this medication?	☐ Yes	☐ No

If “No”, please ignore this line. If “Yes”, what were the side effects? Use the space below:

PART 6: SUBSTANCE USE

Have you ever used substances?	☐ Yes	☐ No	☐ Decline to answer

If “No”, please ignore this line. If “Yes,” check all that apply:

1. ☐ Alcohol	8. ☐ Hallucinogens (LSD)	16. ☐ Nicotine/Tobacco
2. ☐ Amphetamines/Speed	9. ☐ Heroin	17. ☐ PCP
3. ☐ Barbiturates	10. ☐ Inhalants	18. ☐ Tranquilizers
4. ☐ Caffeine	11. ☐ Marijuana	19. ☐ Other
5. ☐ Cocaine	12. ☐ Methadone	20. ☐ Other
6. ☐ Crack Cocaine	13. ☐ Methamphetamine	21. ☐ Other:
7. ☐ Ecstasy	14. ☐ Painkillers	22. ☐ Other:

If “None”, please ignore the next four lines. If “Yes”, please use the space below to provide more information on your use of each substance checked above (indicate the substance by showing the corresponding number as listed above.

You may also repeat the name of the substance(s) if you wish to do so:

Substance #(s):	Name(s):

How old were you when you first used this substance?	

How old were you when you last used this substance?	

Are you currently using this substance?	☐ Yes	☐ No	☐ Decline to answer

If you answered “No” to the previous question, please ignore the next three lines. If “Yes”, please use the space below to provide additional information on your use of this substance:

How often do you use this substance?	
How much of this substance do you use each time?	

Would you like to add **additional** substances?	☐ Yes	☐ No	☐ Decline to answer

If “No”, please ignore the next four lines. If “Yes”, please use the space below to provide additional information on your use of this substance(s):

Substance #s:	Name(s):
How old were you when you first used this substance(s)?	
How old were you when you last used this substance(s)?	

Are you currently using this substance?	☐ Yes	☐ No	☐ Decline to answer

If “No”, please ignore the next three lines. If “Yes”, please use the space below to provide additional information on your use of this substance:

How often do you use this substance?	
How much of this substance do you use each time?	

Would you like to add **additional** substances?	☐ Yes	☐ No	☐ Decline to answer

If “No”, please ignore the next four lines. If “Yes”, please use the space below to provide additional information on your use of this substance(s):

Substance #(s):	Name(s):
How old were you when you first used this substance(s)?	
How old were you when you last used this substance(s)?	

Are you currently using this substance(s)?	☐ Yes	☐ No	☐ Decline to answer

If you answered “No” to the previous question, please ignore the next three lines. If “Yes”, please use the space below to provide additional information on your use of this substance:

How often do you use this substance(s)?	

How much of this substance do you use each time?	

Would you like to add additional substances(s)?	☐ Yes	☐ No	☐ Decline to answer

If you answered “No” to the previous question, please ignore the next four lines. If “Yes”, please use the space below to provide additional information on your use of this substance:

Substance #(s):	Name(s):

How old were you when you first used this substance(s)?	

How old were you when you last used this substance(s)?	

Are you currently using this substance(s)?	☐ Yes	☐ No	☐ Decline to answer

If “No”, please ignore the next three lines. If “Yes”, please use the space below to provide additional information on your use of this substance:

How often do you use this substance(s)?	

How much of this substance(s) do you use each time?	

Additional information/instruction regarding your use of substance(s).

Have you had any emotional/behavioral problems?	☐ Yes	☐ No

If you answered “No” to having had any emotional/behavioral problems, please proceed to the next question. If “Yes,” please select the emotional/behavioral problems that apply:

☐ Assaults others	☐ Extreme worrier	☐ Indecisive
☐ Breaks things	☐ Fire setting	☐ Impulsive
☐ Chronic lying	☐ Frequently daydreams	☐ Lack of attachment
☐ Disobedient	☐ Frequently tearful	☐ Not trustworthy
☐ Distrustful	☐ Hostile/angry mood	☐ Often sad
☐ Drug use	☐ Hyperactive	☐ Other:
☐ Easily distracted	☐ Immature	☐ Other:

Are you currently taking any medications?	☐ Yes	☐ No

If “No”, please ignore the next three lines. If “Yes”, please enter the name of the medication. Use the space below:

What was the daily dosage?	When did you start this medication?

When did you start this medication?	

Are you currently taking any other medications?	☐ Yes	☐ No

If “No”, please ignore the next three lines. If “Yes”, please enter the name of the next medication below:

What was the daily dosage?	When did you start this medication?

When did you start this medication?	

Are you currently taking any other medications?	☐ Yes	☐ No

If “No”, please ignore the next three lines. If “Yes”, please enter the name of the next medication below:

What was the daily dosage?	When did you start this medication?

When did you start this medication?	

Do you have any known allergies?	☐ Yes	☐ No

If “No”, please ignore the next line.

“Yes”, please list your known allergies below:

Did you have past non-psychiatric hospitalizations or surgeries?	☐ Yes	☐ No

If you answered “No” to the previous question, please ignore the next line. If “Yes”, please list your past non-psychiatric hospitalizations or surgeries below:

PART 7: MEDICAL HISTORY

Have you had any non-psychiatric medical conditions?	☐ Yes	☐ No

If “Yes,” please select the past non-psychiatric medical conditions that apply:

☐ Alzheimer's/Dementia	☐ Endocrine/Hormone Problems	☐ Thyroid Disease
☐ Anemia	☐ Epilepsy or Seizures	☐ Tuberculosis
☐ Arthritis	☐ Genital/Gynecological Problems	☐ Urological Problems
☐ Asthma	☐ Eye Problems	☐ Viral Illness/Herpes
☐ Behavioral Problems	☐ Head Injury	☐ High Cholesterol
☐ Birth Defects	☐ Fibromyalgia	☐ HIV Positive or AIDS
☐ Cancer	☐ Gastrointestinal Problems	☐ Heart Disease
☐ Ear/Nose/Throat Problems	☐ Lung Disease	☐ High Blood Pressure
☐ Chronic Fatigue	☐ Migraine or Cluster Headaches	☐ Intellectual/Developmental Disability
☐ Eating Disorder	☐ Neurological Problems	☐ Kidney Problems
☐ Chronic Pain	☐ Skin Disease	☐ Liver Problems/Hepatitis
☐ Diabetes	☐ Sleep Apnea	☐ Other:
☐ Emotional Problems	☐ Stroke	☐ Other:

Did you have any childhood conditions?	☐ Yes	☐ No

If you answered “Yes” to having had any childhood conditions, please select the childhood conditions that apply:

☐ Asthma	☐ Intellectual/Developmental Disability	☐ Rheumatic fever
☐ Autism	☐ Lead poisoning	☐ Scarlet fever
☐ Chickenpox	☐ Mumps	☐ Tuberculosis
☐ Diphtheria	☐ Pneumonia	☐ Whooping Cough
☐ Ear infections	☐ Poliomyelitis	☐ Other:
☐ German Measles	☐ Red measles	☐ Other:

PART 8: SOCIAL HISTORY

Please select any family members present during childhood	

	Entire childhood	Part of childhood	Not present	Not applicable
Biological Mother	☐	☐	☐	☐
Biological Father	☐	☐	☐	☐
Adoptive Mother	☐	☐	☐	☐
Adoptive Father	☐	☐	☐	☐
Stepmother	☐	☐	☐	☐
Stepfather	☐	☐	☐	☐
Brother(s)	☐	☐	☐	☐
Sister(s)	☐	☐	☐	☐

Was there anyone else present during your childhood?	☐ Yes	☐ No

If “No”, please ignore the next line. If “Yes”, who was/were this/these person(s)?

When were they present?	☐ Entire Childhood	☐ Part of Childhood

Please describe your childhood family experience:

☐ Outstanding home environment	☐ Normal home environment	☐ Chaotic home environment
☐ Neglected	☐ Witnessed physical/verbal/sexual abuse towards others	
☐ Experienced physical/verbal/sexual abuse from others	☐ Decline to answer	

Were you emancipated from home?	☐ Yes	☐ No	☐ Decline to answer

If “Yes”, how old were you when you were emancipated?	

Please describe your living situation:

☐ Housing is adequate	☐ Homeless	☐ Housing is overcrowded
☐ Dependent on others for housing	☐ Housing is dangerous/deteriorating	
☐ Living companions are dysfunctional		

Describe your social support system:

☐ Supportive network	☐ Few friends	☐ Substance use-based friends
☐ No friends	☐ Distance from family of origin	☐ Decline to answer

Please describe your financial situation:

☐ No current financial problems	☐ Large indebtedness	☐ Poverty or below-poverty income
☐ Impulsive spending	☐ Relationship conflicts over finances	☐ Decline to answer

Please describe your employment status:

☐ Employed and satisfied	☐ Employed but dissatisfied	☐ Unemployed	
☐ Coworker conflicts	☐ Supervisor conflicts	☐ Unstable work history	☐ Disabled

Please describe your legal history (if you choose to do so)**:**

☐ No legal problems	☐ Now on parole/probation	☐ Arrest(s) not substance-related
☐ Arrest(s) substance-related	☐ Court ordered this treatment	☐ Decline to answer

Please describe your military history:

☐ Never in military	☐ Served in the military - no incident	☐ Served in the military - with incident(s)
☐ Currently serving in the military	☐ Honorable discharge	☐ Decline to answer

Please describe your sexual orientation (if you choose to do so)**:**

☐ Asexual	☐ Bisexual	☐ Straight or heterosexual
☐ Lesbian, gay, homosexual	☐ Queer	☐ Not listed
☐ Don't know	☐ Decline to answer	

Describe your sexual activity (if you choose to do so)**:**

☐ Currently sexually active	☐ Currently sexually satisfied	☐ Currently sexually dissatisfied
☐ History of promiscuity	☐ History of unsafe sex	☐ Not currently sexually active
☐ Decline to answer		

Describe your community, recreational, hobbies, and spiritual activities (if you choose to do so)**:**

Are you currently active in community/recreational activities?	☐ Yes	☐ No	☐ Decline to answer
Were you formally active in community/recreational activities?	☐ Yes	☐ No	☐ Decline to answer
Do you currently engage in hobbies?	☐ Yes	☐ No	☐ Decline to answer
Do you currently participate in any spiritual activities?	☐ Yes	☐ No	☐ Decline to answer

Describe your relationship history (if you choose to do so)**:**

☐ Married	☐ In a relationship	☐ Single
☐ Separated	☐ Divorced	☐ Widowed
☐ Decline to answer		

Do you have children?	☐ Yes	☐ No	☐ Decline to answer

If "Yes", where are they currently living?	☐ Children living at home	☐ Children living elsewhere

You have done well so far. Please continue to the next section – your development history.

PART 9: DEVELOPMENTAL HISTORY

Were there problems during your mother's pregnancy?	☐ Yes	☐ No	☐ Decline to answer

If “Yes,” what type of problems? (Please select all that apply):

☐ Alcohol	☐ Drug use	☐ High blood pressure
☐ Bleeding	☐ Emotional stress	☐ Kidney infection
☐ Cigarette use	☐ German measles	☐ Other:

Were there any complications during your birth?	☐ Yes	☐ No	☐ Decline to answer

Describe the circumstances surrounding your birth:

☐ Normal delivery	☐ Difficult delivery	☐ Cesarean delivery

How much did you weigh at birth? (Pounds and Ounces)	

Did you experience any health problems during infancy?	☐ Yes	☐ No	☐ Decline to answer

If “Yes,” what issues did you experience during infancy?

☐ Feeding problems	☐ Sleeping problems	☐ Toilet training problems

Did you experience any delayed developmental milestones?	☐ Yes	☐ No	☐ Decline to answer

If you answered “Yes” to the previous question, what delayed developmental milestones did you experience? (check all that apply):

☐ Controlling bladder	☐ Riding bicycle	☐ Sleeping alone
☐ Controlling bowels	☐ Feeding self	☐ Speaking sentences
☐ Dressing self	☐ Rolling over	☐ Sitting
☐ Engaging peers	☐ Speaking words	☐ Other:
☐ Riding tricycle	☐ Playing cooperatively	☐ Other:

You are now going to the last section.

Please continue to the last section – your family history.

PART 10: FAMILY HISTORY

Please list any psychiatric conditions your family members have been treated for:

☐ ADHD	☐ Panic attacks	☐ Psychiatric hospitalization
☐ Alcohol problems	☐ Post-traumatic stress disorder	☐ Schizophrenia
☐ Anxiety	☐ Bipolar disorder/Manic depression	☐ Other:

Please list all medical conditions your family members have been diagnosed with:

☐ Anemia	☐ Eating Disorder	☐ Migraine or Cluster Headaches
☐ Arthritis	☐ Epilepsy or Seizures	☐ Kidney Problems
☐ Asthma	☐ Genital/Gynecological Problems	☐ Neurological Problems
☐ Behavioral Problems	☐ High Cholesterol	☐ Stroke
☐ Alzheimer's/Dementia	☐ Emotional Problems	☐ Thyroid Disease
☐ Diabetes	☐ Eye Problems	☐ Tuberculosis
☐ Birth defects	☐ Fibromyalgia	☐ Sleep Apnea
☐ Ear/Nose/Throat Problems	☐ Head Injury	☐ Skin Disease
☐ Cancer	☐ HIV Positive/AIDS	☐ Urological Problems
☐ Chronic Fatigue	☐ Heart Disease	☐ Thyroid Disease
☐ Endocrine/Hormone Problems	☐ Liver Problems/Hepatitis	☐ Viral Illness/Herpes
☐ Gastrointestinal Problems	☐ Intellectual/Developmental Disability	☐ Other:
☐ High Blood Pressure	☐ Lung Disease	☐ None

“Do your family members have other diagnosed medical conditions? If so, please list them here:

PART 11: ANY OTHER ADDITIONAL INFORMATION

Is there additional information about anything? If so, add it here:

THE END

Thank You for Your Time and Cooperation.

We sincerely appreciate the time and effort you've put into completing this form. Your thoroughness helps us understand your unique health needs, allowing us to create the most effective treatment plan tailored just for you.

Welcome to the Joy of Life Clinic! We're committed to providing you with the best care and support on your journey to better health. Together, we can achieve the best possible outcomes.

Please feel free to reach out with any questions or concerns—we're here to help and work with you.

The Joy of Life Clinic