DR KELLY ASSOCIATES LLC

24 North Third Avenue • Suite 203B • Highland Park • NJ 08904
908-349-0822 • FAX: 723.335.4888 • *www.drshalondakelly.com*

INTAKE FORM

Full Name(s): _____

_____

_____

_____

Address: _____

_____

Phone(s): Name: _____ (H)_____ (W) _____ (cell) _____

May we leave a message? □ Yes □ No

Phone(s): Name: _____ (H)_____ (W) _____ (cell) _____

May we leave a message? □ Yes □ No

Emails: (caller) _____ other (specify) _____

May we email you? □ Yes □ No

Hours Available:_____

Family Constellation:

Name/Family Status	Date of Birth	Age	Sex	Edu.	Occupation	Location
Identified Patient (IP)						

Person Calling: _____*DOB (IP): _____

Referred by (if any): _____

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INTAKE FORM

Marital Status: Length of Relationship:

□ Never Married □ Domestic Partnership/Cohabitation □ Married _____ years /months

□ Separated □ Divorced □ Widowed

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No

□ Yes, previous therapist/practitioner, length of treatment/no. of sessions: _____

_____

Are you currently taking any prescription medication?

□ No

□ Yes

For what condition and when? _____

Please list: _____

Do you have Mental Health coverage?

□ Yes Name of Insurance:_____

□ No

*SSN of primary insured: _____ *DOB of primary insured: _____

*SSN of client(s): _____

*NOTE: *means that the information is necessary for insurance reimbursement.*

Do you utilize other MH services? (e.g. psychiatrist, child study team)

□ Yes Describe: _____

□ No

PLEASE PROVIDE A XEROX COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD.

Household Income: _____ yearly / monthly / biweekly *(circle)*

Dependents: _____

Presenting Problem:

_____

_____

_____

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INTAKE FORM:
GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? *(please circle)*

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? *(please circle)*

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns:

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression?

□ No □ Yes If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?

□ No □ Yes If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: _____

8. Do you drink alcohol more than once a week? □ No □ Yes

If yes, please specify the following: Amount / Duration _____

9. How often do you engage recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

If yes, please specify the following: Amount / Duration _____

10. Are you currently in a romantic relationship? □ No □ Yes If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

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INTAKE FORM:
FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle		List Family Member
Alcohol/Substance Abuse	yes	no	
Anxiety	yes	no	
Depression	yes	no	
Domestic Violence	yes	no	
Eating Disorders	yes	no	
Obesity	yes	no	
Obsessive Compulsive Behavior	yes	no	
Schizophrenia	yes	no	
Suicide Attempts	yes	no	

ADDITIONAL INFORMATION

1. Are you currently employed? □ No □ Yes If yes, what is your current employment situation?

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

4. What do you consider to be some of your weaknesses?

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

6. What is your legal status, dates, and reason? (e.g. arrests for domestic/substance abuse, juvenile, etc.)

_____