FRONTIER MEDICAL & BEHAVIORAL CENTER
www.frontiermbc.com

Behavioral Intake Form

Name_____Date_____

Date of Birth: _____

☐ DFS Contact; PLR/Case Manager _____

☐ Foster Parent Information: _____

Therapist (if Applicable): _____

What are the problem(s) for which you are seeking help?

_____

_____

Past Medical History

Allergies_____ Current Weight _____ Height _____

Medical Problems: ☐ Hypertension ☐ Diabetes ☐ Thyroid Disease ☐ Seizure ☐ High Cholesterol
☐ Chronic Pain ☐ Arrythmia ☐ Others: _____

Surgeries: _____

List ALL current prescription and over the counter medications (or provide list)

_____

_____

_____

Any History of Abnormal EKG? ☐ No ☐ Yes - if yes, what abnormality? _____

Were there complications with your birth? ☐ No ☐ Yes

Past Psychiatric History

Previous of Psychiatric Hospitalization: ☐ No ☐ Yes , If Yes, How many times? _____

Past Psychiatric Medications: _____

Family Psychiatric History: Has anyone in your family been diagnosed with or treated for:

		Relative			Relative
Bipolar disorder	☐ No ☐ Yes	_____	Schizophrenia	☐ No ☐ Yes	_____
Depression	☐ No ☐ Yes	_____	Post-traumatic stress	☐ No ☐ Yes	_____
Anxiety	☐ No ☐ Yes	_____	Alcohol abuse	☐ No ☐ Yes	_____
Anger	☐ No ☐ Yes	_____	Other substance abuse	☐ No ☐ Yes	_____
Suicide	☐ No ☐ Yes	_____	Violence	☐ No ☐ Yes	_____

If yes, who had each problem? _____

Social / Occupational/ Relationship History

Tobacco Use: ☐ No ☐ Yes, if yes. How many packs and years? _____

Alcohol Use: ☐ No ☐ Yes, if yes. How many p/week and how long? _____

Substance Use Screening

Have you ever been treated for alcohol or drug use or abuse? ☐ No ☐ Yes

Have you ever felt you ought to cut down on your drinking or drug use? ☐ No ☐ Yes

Have people annoyed you by criticizing your drinking or drug use? ☐ No ☐ Yes

Have you ever felt bad or guilty about your drinking or drug use? ☐ No ☐ Yes

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ☐ No ☐ Yes

Do you think you may have a problem with alcohol or drug use? ☐ No ☐ Yes

Have you ever abused prescription medication? ☐ No ☐ Yes

Check if you have ever tried the following:

	Yes No	If yes, how long and when did you last use?
Methamphetamine	☐ No ☐ Yes	_____
Cocaine	☐ No ☐ Yes	_____
Stimulants (non prescribed)	☐ No ☐ Yes	_____
Heroin	☐ No ☐ Yes	_____
LSD or Hallucinogens	☐ No ☐ Yes	_____
Marijuana	☐ No ☐ Yes	_____
Pain killers (not as prescribed)	☐ No ☐ Yes	_____
Methadone	☐ No ☐ Yes	_____
Tranquilizer/sleeping pills	☐ No ☐ Yes	_____
Alcohol	☐ No ☐ Yes	_____
Ecstasy	☐ No ☐ Yes	_____

Other _____

Were you adopted? ☐ No ☐ Yes Where did you grow up? _____

Are you currently: ☐ Married ☐ Partnered ☐ Divorced ☐ Single ☐ Widowed

Who lives in the same household? _____

Highest level of education attained: ☐ GED ☐ High School ☐ College ☐ Masters ☐ Other_____

Trauma History of Abuse: ☐ Emotional ☐ Sexual ☐ Physical ☐ Neglect ☐ Other _____

Are you currently: ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

☐ Employed - If yes, occupation and employer: _____