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INTAKE FORM

Thank you for contacting BETA. To better serve your needs please complete this form prior to your first visit.

Date: _____

Name: _____

DOB: _____

Address: _____

Phone: _____

Emergency Contact: _____

Relationship: _____

Phone: _____

Have you seen a therapist before? Yes or No (please circle)

Please indicate which of the following you have experienced.

Depression

Sexual Identity

Anxiety

ADHD

Grief

PTSD

Eating Disorder

Abuse

Trauma

Relationship

Self Harm

Addiction/Substance Use

Academic Challenges

Bullying

School Refusal

Anger Management

Other: _____

Have you been hospitalized in the past? Yes or No (please circle)

If yes, the date: _____

Are you currently taking medication? Yes or No (please circle)

If yes, please list the current medications you are taking:

Name of Prescriber:

Do you have a Primary Care Physician? Y or No (please circle)

Name of Primary Care Physician: _____

Address: _____

Phone: _____

Is there anything else that you would like your therapist to know to better serve your needs?

