Summit Psychological Services

New Patient Intake Form

Date:

Personal Information		
First Name:	Last Name:	
DOB:	Gender:	SSN:
Street Address:		
City:	State:	Zip:
Cell Phone #:	Home Phone#:	
Email:		

Insurance Information- Primary Insurance		
Insurance:	Policy/ID #:	Group #:
Policy Holder:	Relationship to Patient:	
Policy Holder's DOB:	Policy Holder's SSN:	

Insurance Information - Secondary Insurance		
Insurance:	Policy/ID #:	Group #:
Policy Holder:	Relationship to Patient:	
Policy Holder's DOB:	Policy Holder's SSN:	

Services Needed		
Individual Therapy	Medication Management	Both
Couples' Counseling	Family Counseling	Other:

Office Location:	Fox Chapel	Seven Fields

Accessibility Concerns (*Will you need to have access to an office that does not have stairs?)*	☐ Yes	☐ No

Scheduling Preferences	
Male	Female
Days:	Times:
Other:	

Treatment/Diagnostic History
Have you seen a mental health practitioner before? When and why was treatment discontinued?
Have you been given a specific mental health diagnosis before?

SUMMIT PSYCHOLOGICAL SERVICES

NEW PATIENT INTAKE FORM

What, if any, psychiatric medications do you currently take?

Current Stressors
What are you struggling with right now?
Are you suffering from suicidal thoughts? Have you ever struggled with wanting to harm yourself in the past? ***(If you are experiencing suicidal thoughts or thoughts of self harm please contact: Resolve Crisis Services 1-888-796-8226 and National Suicide Prevention Line 1-800-273-8255 as well as other available resources).***

Additional Concerns
Are you dealing with any addiction issues that your practitioner should know about?
Are you dealing with any legal problems that your practitioner should know about?

Referral Source
How did you hear about our practice?

Intake Notes
Practitioner recommendations, additional information, etc.