

## NEW PATIENT INTAKE FORM

If you are interested in setting up an appointment for assessment/evaluation, please complete this form and fax to 520-334-2006. Someone will call you to discuss your needs further and schedule an appointment. Note: Dr. Beldotti is accepting new patients for assessments but is NOT taking any patients for emergency/crisis evaluations or counseling.

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Best contact person: \_\_\_\_\_ Tel: \_\_\_\_\_

Email (print): \_\_\_\_\_

Full address of pt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Referred by: \_\_\_\_\_

Reason for Referral / Reason for evaluation (include as much detail as possible):

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Does the person have any history of depression, anxiety, trauma, ADHD, Autism, thinking or learning problems (if yes, what): \_\_\_\_\_

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Is person currently receiving counseling? \_\_\_\_\_ Provider: \_\_\_\_\_

Any history of inpatient psychiatric treatment? \_\_\_\_\_

Any past suicidal ideation or attempts (when?): \_\_\_\_\_

Any problems with being violent or aggressive \_\_\_\_\_

Any medical conditions or history of head injuries, stroke, seizures, etc.: \_\_\_\_\_

Any problems with addiction/ substance abuse (if teen/adult): \_\_\_\_\_

Any current medication for ADHD/Psych (list): \_\_\_\_\_

Any medications that cause drowsiness: \_\_\_\_\_

Does person have any problems with vision or hearing: \_\_\_\_\_

Can person speak and communicate okay in English: \_\_\_\_\_

Is English the primary language spoken: \_\_\_\_\_

Did an attorney recommend this evaluation: \_\_\_\_\_

Will these results be shared with an attorney for any purpose (explain): \_\_\_\_\_

Will these results be used for a disability or worker's comp claim or hearing: \_\_\_\_\_

Any other relevant history or info: \_\_\_\_\_

**FOR ADULTS:**

Currently on disability? \_\_\_\_\_ If yes, what for: \_\_\_\_\_

Currently on worker's comp: \_\_\_\_\_

Currently employed (what, where): \_\_\_\_\_

Highest education level completed: \_\_\_\_\_

**FOR CHILDREN & ADOLESCENTS:**

Mother's Name: \_\_\_\_\_ Tel: \_\_\_\_\_

Mother's Email: \_\_\_\_\_ Lives with child? \_\_\_\_\_

If not, Mother's address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Tel: \_\_\_\_\_

Father's Email: \_\_\_\_\_ Lives with child? \_\_\_\_\_

If not, Father's address: \_\_\_\_\_

Other Guardian: \_\_\_\_\_ Tel: \_\_\_\_\_

Guardian's Email: \_\_\_\_\_ Lives with child? \_\_\_\_\_

Who has physical custody of the child: \_\_\_\_\_

Who has decision-making abilities regarding the child: \_\_\_\_\_

School Info: Grade: \_\_\_\_\_ School: \_\_\_\_\_

Any Special Education services / IEP / 504 Plan? \_\_\_\_\_

Any past evaluations? \_\_\_\_\_

Issues that you would like assessed (list in order of priority, starting with #1): ____ ADD/ADHD    ____ Autism / Aspergers    ____ IQ    ____ Development Delay ____ Cognitive (thinking, attention, memory, etc.).    ____ Possible Dementia ____ Academic skills (note: <u>insurance does not cover this</u> , would be private pay) ____ Psychological (mood, anxiety, depression, etc.). _____ Other: _____
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