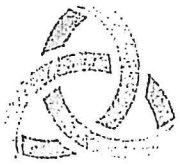

TRINITY
WELLNESS CENTER

Leighton Morgan, PA-C

INTAKE FORM

Name: _____ Date of Birth: _____

Address:

_____

Number and Street City State Zip

Phone (C) _____ (W) _____

Email: _____

Single ___ Married ___ Separated ___ Divorced ___ Widowed ___

What are your main concerns for wanting to be seen today?

_____

How long have you had this issue?

_____

Previous mental health care? Previous therapy? When and where?

_____

_____

Previous psychiatric hospitalization? When and where?

Have you ever attempted suicide?

Is there any history of mental illness in your family? Explain.

Personal current drug /alcohol use. Any substance abuse treatment?

Current medical problems:

Were you delivered by C-Section? Yes No

How was your health as a child? Illness and treatment, explain.

Current medications and doses:

Current supplements:

Were you ever on an oral contraceptive or long-term antibiotic? Yes No

If yes, please list which one(s)?

Any head injuries|concussions? Yes No

If yes, explain:

Have you ever had any surgeries? Yes No

If yes, explain:

Any toxic exposures? (example: metals, mold, infections, tick bites) Explain.

Educational History:

Living Situation:

Occupational history:

Spiritual history:

Stress reducing activities (exercise, etc.):

General eating habits, special diets, gluten-free eating:

Sleep habits:

Support system: