STEPHAN J. KITSON
RIVERSAGE FAMILY COUNSELING
100 Jenkins Ranch Rd. Suite E 1, DURANGO, CO 81301
970-422-3830

New Patient Evaluation Form

Please fill out the following confidential intake form prior to your first appointment with Dr. Kitson. By answering these questions accurately and thoughtfully, you will be helping set the therapeutic process in motion. If you are uncomfortable answering any of these questions, please feel free to leave them blank; we can discuss them in more detail at our initial evaluation.

PATIENT IDENTIFICATION:

Name: _____ SSN#:_____
Birthdate: _____ Age: _____ Occupation:_____
Marital Status: _____ Preferred Phone Number: (_____)_____
Email address: _____
Street Address: _____

How did you hear about Dr. Kitson?

_____

Please list two Emergency Contacts:
Name: _____Phone: (_____)_____
Name: _____Phone: (_____)_____

Name of Insurance Company if you plan to use Insurance: _____

Policy Holder's Name and relation to you: _____

Policy Holder's ID #: _____ Policy Holder's SS#: _____

Group #: _____ Type of Plan PPO HMP indemnity EAP or Other**:** _____

Phone number for verification of benefits/eligibility (on back of card): (_____)_____

Address to send billing (on back of card):_____

Policy Holder's Employer: _____

PURPOSE OF CONSULTATION: (In your own words, please describe the problems you are currently experiencing which have prompted you to seek treatment):

_____
_____
_____
_____

PRESENTING SYMPTOMS: Please check any symptoms that may pertain to you

- ☐ **Depressed or sad mood**
- ☐ **Difficulty enjoying usual activities**
- ☐ **Unintentional weight loss or weight gain**
- ☐ **Sleeping too much or not enough**
- ☐ **Feeling agitated or sluggish**
- ☐ **Lacking energy/always tired**
- ☐ **Feeling guilty or worthless**
- ☐ **Poor focus and concentration**
- ☐ **Thoughts of death or suicide**
- ☐ **Inflated self-esteem**
- ☐ **Decreased need for sleep or going for days without sleeping**
- ☐ **Excessive talking**
- ☐ **Racing thoughts**
- ☐ **Feeling highly distractible**
- ☐ **Try to do or accomplish way too much in a day**
- ☐ **Impulsive behavior**
- ☐ **Seeing or hearing things that may not be real**
- ☐ **Feeling like people are watching you or out to get you**
- ☐ **Often tense or unable to relax**
- ☐ **Excessive worrying**
- ☐ **Panic Attacks**
- ☐ **Afraid/unable to leave home**
- ☐ **Extreme unreasonable fears**
- ☐ **Intense fear of social situations**
- ☐ **Cannot prevent repetitive thoughts**
- ☐ **Cannot prevent repetitive behaviors**
- ☐ **Intrusive, upsetting memories of past events**
- ☐ **Always on guard or never feel safe**
- ☐ **Body overreacts to "stress"**

LIFE PROBLEMS THAT CURRENTLY AFFECT YOU:

- ☐ **Problems within my family**
- ☐ **Problems among my friends/community**
- ☐ **Educational problems**
- ☐ **Occupational/Job problems**

- ☐ **Housing problems**
- ☐ **Financial/Economic problems**
- ☐ **Problems with the law, legal system**
- ☐ **Destructive/violent thoughts or behaviors**
- ☐ **Attempts to hurt, harm, or mutilate self**
- ☐ **Anger outbursts**
- ☐ **Discipline problems at work**
- ☐ **Careless, high-risk behavior**

PAST PSYCHIATRIC HISTORY:

Have you ever been hospitalized for psychiatric reasons? Circle YES or NO. If yes, please elaborate:

Have you ever seen a psychiatrist on an outpatient basis? Circle YES or NO. If yes, please give details:

Have you ever received counseling or psychotherapy in the past? Circle YES or NO. If yes, please elaborate:

Which psychiatric medications have you taken in the past and what were the benefits and/or side effects you experienced?

Are you currently taking any psychiatric medications? Circle YES or NO
If yes, please list all current medications along with dosages and prescribing physician name:

GENERAL MEDICAL HISTORY:

Do you have a Primary Care Physician (PCP)? Circle YES or NO
If yes, please list name of PCP and his or her phone # and address:

Date of Last Physical Exam: _____Date of Last Lab work:_____

Do you take any prescription medications for your general medical problems? Circle YES or NO. If yes, list:

Do you take over-the-counter medications, herbal or dietary supplements, or vitamins? Circle YES or NO
If yes, please list:

Are you allergic to any medications? Circle YES or NO. If yes, please list medications and allergic reactions:

Have you undergone any surgical procedures? Circle YES or NO. If yes, please list all surgical procedures:

Do you have any problems with chronic physical pain or fibromyalgia? Circle YES or NO If yes, please describe and rate your average pain level using the scale below:

Circle one 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (worst)

Have you ever suffered a severe head injury with loss of consciousness or a concussion? Circle YES or NO
If yes, please describe:

ALCOHOL, DRUG AND TOBACCO USE:

ALCOHOL: Would you say you are ☐ a non-drinker ☐ a social drinker ☐ a regular drinker

☐ Have a drinking problem ☐ an alcoholic

Regardless of the box you checked, please describe the frequency of your alcohol use and what kind of alcohol and how much you drink, including date of last use:

Have you had any problems related to use or undergone treatment for use? Circle YES or NO
If yes, please describe (Legal, Financial, Health, or Relationship problems):

DRUG AND/OR PRESCRIPTION DRUG USE: Check if none _____
Would you say you ☐ are a recreational drug user ☐ have a drug problem ☐ have a drug addiction? Please checkmark which substances below you regularly use:

- ☐ Benzodiazepines (Klonopin, Valium, Xanax, Ativan)
- ☐ Caffeine
- ☐ Marijuana/THC
- ☐ Cocaine/Crack
- ☐ Designer Drugs (such as Club Drugs: G, X)
- ☐ Hallucinogens (LSD, Mushrooms)
- ☐ Inhalants (Gasoline, Glue, Aerosol)
- ☐ Methamphetamines (Speed, Ice, Adderall)
- ☐ Opiates/Methadone (Vicodin, Oxycontin, Heroin)
- ☐ Prescription Pills (please list):

_____

_____

- ☐ Tobacco

Which of these have you experienced related to your drug use ☐ Blackouts ☐ Bad reactions ☐ Withdrawal symptoms ☐ Cravings ☐ Overdoses ☐ Tolerance ("Could not get high no matter how much I used") ☐ Preoccupation (Spent lots of time finding and using substance) ☐ Failed attempts to cut down or control use ☐ Detoxification in a hospital ☐ Other problems:

_____

ADDITIONAL INFORMATION YOU WOULD LIKE DR. KITSON TO KNOW

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Thank you for taking the time to fill out this confidential form accurately and thoughtfully.