Psychology Intake Information – Adult

The following information will be utilized by your provider for treatment purposes. Please complete this form to the best of your ability.

Background Information

Name: _____

Gender: _____ Relationship Status: _____

Ethnicity: _____ Sexual Orientation: _____

Are there any accommodations that you need to be able to access services? If yes, please describe:

_____

_____

_____

_____

Treatment Needs

Please provide some information about your reasons for seeking therapy. Please state symptoms, emotional concerns, sleep problems, school/employment issues, relationship difficulties, and any additional information that may pertain to treatment.

_____

_____

_____

_____

_____

Have you had any significant changes occur in your life in the last year? If yes, please describe:

_____

_____

_____

_____

Do you have, or have you ever had, thoughts of wanting to harm yourself or someone else? If yes, please explain and indicate when they occurred:

_____

_____

_____

_____

Please feel free to share any information about your background that you would like your psychologist to know. This may include information about religion, spirituality, ethnicity, culture, sexual orientation, or other areas that are important to you and you would like considered during your treatment.

_____

_____

_____

_____

Medical History

Current Height: ____ ft ____ in Current Weight: _____ lbs.

Primary Care Physician: _____ Address: _____

Telephone: ( ) _____ - _____ Date of last physical exam: _____

In order to provide you with the best possible treatment, it is recommended that we coordinate care with your primary care physician. If you are willing to provide consent for treatment coordination, please complete the enclosed release of information form found later in this packet. If you would prefer that we do not contact your primary care provider, please indicate that below.

_____ I am interested in receiving coordinated care _____ I prefer to decline coordinated care at this time

Please describe any health problems or allergies that you are receiving care for:

_____

_____

Have you received prior treatment for mental health problems? If so, please list the diagnosis, when treatment occurred, name of provider, and what type of treatment was received (e.g., therapy, medication).

_____

_____

Are you currently taking any medications? If so, please list medication and dose:

_____

_____

Have you previously discontinued any psychiatric medications? If so, please list the name of the medication and the reason for discontinuing:

_____

_____

_____

Is there any family history of mental health problems, substance abuse, or chronic health problems (e.g., cardiac, diabetes, thyroid)? If so, please list:

_____

_____

_____

Do you drink alcohol? Yes No

If yes, approximately how many drinks do you have when you drink? _____

If yes, how often do you drink alcohol? _____

Do you have any concerns about your alcohol use? Yes No

Do you use any illegal substances or misuse any prescription medications, such as taking too much of medication prescribed to you, or taking a medication that you do not have a prescription for?

If yes, please specify: _____

Do you have any concerns about other potentially addictive behaviors (e.g., eating, gambling, internet use)?

If yes, please specify: _____

Developmental History

Are you aware of any pregnancy/birth complications or delays in developmental milestones (crawling, walking, talking, etc.)? If so, please list:

_____

_____

_____

Educational and Employment History

What is the highest level of education that you completed: _____

Name of Institution	Location (City, State)	Dates Attended	Grades	Degree Rec'd

Were you ever in a special education or learning disabled classes? Y N

In a gifted or advanced program? Y N

Additional Comments: _____

_____

Employer / City, State	Job/ Occupation	Dates	Reason for Leaving

Volunteer Activities:

_____

_____

Concerns or additional comments related to employment:

_____

_____

Trauma History

Have you ever experienced emotional abuse, physical abuse, sexual abuse/rape, neglect, domestic violence, terrorist acts, wartime trauma, motor vehicle accident, natural disasters, or a head injury? If yes, please specify:

_____

_____

Social History

Who is currently residing in your household? _____

Who are the primary support people in your life? _____

_____

Are you satisfied with your current level of support? Yes No

Please Explain: _____

_____

Legal History

Do you have a history of tickets/legal actions? If so, please specify the charge, date, and outcome:

_____

_____

_____

Thank you for taking time to complete this questionnaire.

Client Signature _____ Date: _____

If this form was not completed by the client who is requesting services, please complete the following:

_____

Name (please print) Date

_____

Signature Relationship to Client