Professional Psychological Services

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INTAKE FORM - ADULT

Name:____
Last First Middle Initial

Date of Birth: ________ /________ /________ Age: ________ Gender: ☐ Male ☐ Female
MM DD YY

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please list any children and their age(s): ____

____

Address: ____
Street and Number

____
City State Zip

Home Phone: (__________) ______________________ May we leave a message? ☐ Yes ☐ No

Cell Phone: (__________) ______________________ May we leave a message? ☐ Yes ☐ No

Email: _____________________________________ May we email you? ☐ Yes ☐ No

Preferred method of contact: ____________________

Referred by: _________________________________

Are you currently employed? ☐ Yes ☐ No

Do you enjoy your job?

☐ Yes

☐ No, please explain:____

____

Is your job a source of stress for you?

☐ No

☐ Yes, please explain: ____

____

General Health and Mental Health Information

How would you rate your current physical health?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any health problems you are currently experiencing: ________________________________

____

Are you currently taking any prescription medication?

☐ No

☐ Yes, please list: ____

____

Have you ever been prescribed psychiatric medications?

☐ No

☐ Yes, please list and provide dates: ____

____

Have you previously received any type of mental health services including psychological testing?

☐ No

☐ Yes, previous provider and reason: ____

____

Do you use: ☐ Alcohol ☐ Drugs ☐ No alcohol/drug history

Have you been treated for alcohol/drug problems before?

☐ No

☐ Yes, previous provider and dates: ____

____

What brings you in for services and what would you like to accomplish?

____

____

____

____

Please check any of the following that you have experienced recently:

- ☐ Depression
- ☐ Suicide Ideation
- ☐ Appetite problems
- ☐ Weight loss/gain
- ☐ Poor attention
- ☐ Distractibility
- ☐ Aggression/violence
- ☐ Hyperactivity
- ☐ Other(s)
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Sleep problems
- ☐ Racing thoughts
- ☐ Anger
- ☐ Irritability
- ☐ Poor concentration
- ☐ Memory problems
- ☐ Voices/visions
- ☐ Paranoia
- ☐ Compulsive behaviors
- ☐ Too much energy
- ☐ Social withdrawal
- ☐ Low energy
- ☐ Blackouts

____

Family Mental Health History

In the section below, please circle yes or no if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (example: mother, father, cousin, etc.).

	Please Circle	List Family Member(s)
Alcohol/Drug Use	Yes / No	
Anxiety	Yes / No	
Depression	Yes / No	
Bipolar Disorder	Yes / No	
Post-traumatic Stress	Yes / No	
Schizophrenia	Yes / No	
Suicide Attempt(s)	Yes / No	
Eating Disorder	Yes / No	
Violence	Yes / No	
Other:		

____ ____________________
Printed name of client Date

____
Signature of client