PSYCHOLOGICAL AFFILIATES
ADULT INTAKE FORM

IDENTIFYING INFORMATION

Full Name: _____ Name You Prefer: _____
Date of Birth: _____ Age: _____ Gender: M____ F____ Social Security #: _____
Mailing Address: _____
_____
Home Phone: _____ Okay to leave a message? Choose One
Work Phone: _____ Okay to leave a message? Choose One
Cell Phone: _____ Okay to leave a message? Choose One
Email Address: _____
Emergency Contact:_____ Relationship to You:_____
Phone: _____
Ethnicity: _____Birthplace (country/state): _____
Relationship Status:
___ Single ___ Committed Rel. ___ Married ___ Separated ___ Divorced ___ Widowed
Highest Degree Earned: _____ School/College: _____
Occupation: _____ Employer: _____
Please list everyone in your household and their relationship to you:
Name Age Gender Relationship to You
_____
_____
_____

PROBLEM IDENTIFICATION

What problem(s) or difficulties bring you here at this time? _____
_____
_____
When did these problem(s) begin? _____
_____
How would you rate the intensity of the problem(s) from 1-10? (1=minimal 10=extreme) _____
Describe your thoughts and feelings regarding your problem(s). _____
_____
What makes the problem(s) better? _____
_____
What makes the problem(s) worse? _____
_____
How does this problem interfere with your daily functioning? _____
_____
How have you tried to cope with this problem(s)? _____
_____

Please check any of the following areas of concern, either past or present:

☐ Alcohol/Drug Abuse	☐ Hopelessness	☐ Paranoia	☐ Anger Control
☐ Homicidal Thoughts	☐ Parenting Concerns	☐ Anxiety	☐ Hostility
☐ Phobias/Panic	☐ Assertiveness	☐ Isolation	☐ School
☐ Attention/Concentration	☐ Impulse Control Problems	☐ Bereavement/Grief	☐ Self-Defeating
☐ Insomnia	☐ Self-Esteem Issues	☐ Communication	☐ Irritability

☐ Suicidal Thoughts/Self-
☐ Work Problems
☐ Domestic Violence
☐ Medical Concerns
☐ Injurious Behaviors

☐ Depression
☐ Legal Issues
☐ Marital/Relationship Problems
☐ Memory

☐ Identity Issues
☐ Sexuality
☐ Stress
☐ Family

☐ Sexual Abuse
☐ Spirituality
☐ Eating/Food

Did you have any attention, learning, or behavioral problems in school? _____
_____
Have you had any legal issues? _____
_____

PSYCHIATRIC HISTORY

Have you had counseling, psychotherapy or psychiatric treatment before? _____Are you currently receiving counseling, psychotherapy or psychiatric treatment? _____

Dates	Reason	Treated By	Type of Treatment	Did it help?

Medical History

Rate your physical health (check one):

Very Good____ Good____ Average____ Declining____ Poor____

Primary Care Provider or Family Physician? _____
Address:_____
_____Phone #:_____

When was your last general medical checkup or physical? _____

Have you had any operations or serious injuries? Please describe:_____
_____
_____
_____

Please list doctors you are seeing, any medical conditions you are getting treatment for, and all medications that you are taking:

Condition/Diagnosis	Doctor	Medication or Treatment

Are you sleeping well? **Yes**____ **No**____ Is your appetite stable? **Yes** ____ **No** ____
Do you tend to experience low mood or low energy during the winter? **Yes** ____ **No** ____

(For women) If you are having menstrual periods…

Are your periods regular? **Yes**____ **No**____

Do you have problems with PMS? **Yes**____ **No**____

Are you using contraception? **Yes**____ **No**____
(What method?_____)

Have you had any of these medical problems? (Check the ones that apply)

____Seizures or Epilepsy ____Thyroid Problems ____Heart Problems

____Hepatitis ____Asthma ____Anemia

____Allergies to Medicines ____Glaucoma ____Urinary Problems

____Other (Please specify):_____

If allergic to medications, list which ones:_____

Have you ever been knocked unconscious or had a concussion? If yes, please explain:_____

_____
_____

Do you use alcohol? If yes how much? _____
_____

Do you drink caffeinated beverages (colas, tea, coffee? If yes how much? _____
_____

Do you use tobacco products? If yes how much?_____

Do you use, or have you ever used marijuana, cocaine or other "recreational" drugs? Please describe:_____
_____

Have you had alcohol or drug problems in the past? What kind?_____
_____

Eating issues: Check all that apply ____Anorexia ____Bulimia ____Food Addiction
____Recent weight gain ____Recent weight loss ____Food Allergies

Social History
List your particular interests and hobbies:_____
_____
_____

How is most of your free time occupied?_____
_____
_____

Have there been any major changes or stresses in your life recently? Please explain?_____
_____

Please list your last three jobs below beginning with your current one. (If you are unemployed or retired, list last position held and dates)

Position	Kind of work	Dates	Reason for Leaving

Family of Origin History
Were you reared by your birth parents? Yes ____No
If "No", please describe:_____
_____

Were/are your parents separated, divorced, never married?
____Separated ____Divorced ____Never Married

Please answer this next section describing your parents:

Still living? (Write in "Yes" or "No")	Father_____	Mother_____
Present age (Write in ages)	Father_____	Mother_____
Age at Marriage (Write in ages)	Father_____	Mother_____
Age at Death (Write in ages)	Father_____	Mother_____
Nationality Background	Father_____	Mother_____
Religious Preference	Father_____	Mother_____
Education (Write in number of years)	Father_____	Mother_____

As a child did you feel closest to your (check one): ____Father ____Mother ____Other
If "Other" please describe:_____

Rate your childhood life: ____Very Happy ____Happy ____Average ____Unhappy

Religious/Spiritual History

Are you involved in religious activity? ____Yes ____No
Please describe/explain:_____
_____
_____

Who referred you for evaluation and treatment?_____

Is there anything else you would like to describe or relate on this form?_____
_____
_____
_____