Grelling Psychology Associates

sensitive, professional care for individuals and families

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ADULT INTAKE FORM

Please print this form and answer the following questions. Bring this with you to our initial session and we will be able to discuss your responses further. This will help me get to know you and provide the best possible treatment. The information you provide is protected as confidential.

Name: ____

Address: ____

____

Email: ____

Best phone number to reach you: (____)____

Is it okay to leave a message at this number? __________

Alternate phone number: (____)____

Name of emergency contact (optional): ____

Phone number of emergency contact (optional): (____)____________________________

Birthdate: ____

Age: _______________

Ethnicity: ________________

Current marital status:

_Single _Separated _Committed Relationship
_Married _Widowed _Other
_Divorced _Dating

Do you have children? ________ If so, what are their ages? _________________________

If you do not live alone, please list who you live with: _________________________________

____

Are you currently employed? __________

If yes, what is your current employment situation? ______________________________

If no, what was your most recent work situation? _______________________________

How did you learn about my psychology practice? _____________________________________

What is your reason(s) for seeking therapy at this time? ______________________________

____

____

Are you currently feeling sad, depressed or irritable more days than not? _______________

Are you grieving the loss of someone(s)? ____

Are you currently troubled by anxiety, panic attacks, or phobia(s)? _____________________

Do you have chronic pain? ____

Please list any medical condition(s) for which you are being treated: ____________________

____

Do you have any problems with your sleep, appetite, energy, concentration, motivation?

__________ (Please circle any/all that apply)

In the past month, have you had any thoughts of harming yourself or thoughts of suicide?

____

Have you ever attempted suicide or intentionally injured yourself? ______________________

In the past month, have you had any thoughts of harming anyone else? ________________

Do you check things too much (e.g. locks, stove) or do calculations repeatedly? __________

Do you have periods of time with excessive energy, little sleep, and yet don't feel tired?

____

Do you ever hear voices that other people don't hear? ________________________________

Have you ever had a problem with alcohol or drugs? __________________________________

Have you ever had any problems with the law? _______________________________________

Does anyone in your family have a history of mental health problems (including anxiety, depression, bipolar disorder, schizophrenia, suicide, alcohol/drug problems)? ____________

____

____

In your current relationship(s), has there been any hitting, threatening to harm, or hurting in any way? ____

Have you ever been physically, sexually or emotionally abused? _______________________

Have you ever been in therapy before? If so, when? __________________________________

Have you ever been hospitalized for mental health reasons? If so, when? _______________

Have you ever been prescribed any psychiatric medications? If so, please list.

____

____

Please list any medications that you are currently taking: ______________________________

____

____

Do you exercise regularly? ____

How much alcohol do you drink in an average week? _________________________________

Do you use marijuana or other drugs? ____

How many caffeinated products do you consume daily? _______________________________

Who can you count on for social support? ____

____

Do you consider yourself spiritual or religious? ______________________________________

What do you consider to be your personal strength(s)? ________________________________

What would you like to accomplish in therapy? ______________________________________

____