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PSYCHOLOGY SUPPORT CENTER
Support & Empower for Success

Adult Intake Form

What type of service are you looking for? Check all that apply

_____Individual Therapy
_____Couples Therapy
_____Family Therapy
_____Stress Management
_____Independent Living Skills

Section 1

Demographic Information

Client name _____ Date _____

Date of birth _____ Age _____ Sex_____

Street Address _____

City _____ State_____ Zip _____

Birthplace _____

Phone _____ Cell phone _____
Is it ok to leave a voicemail? _____

Email address _____
Would you like to receive email communication? _____

Insurance Information

Which Insurance: _____

Name on Policy: _____

ID Number: _____

Group Number: _____

Section 2

Career/Leisure Information

Are you currently employed? If yes, what is your occupation and are you satisfied with it?

_____
_____

Have you ever been fired from a job? If yes, please explain further.

_____
_____

What is your highest level of education and in what field of study?

_____
_____

How do you spend your free time?

_____
_____

Section 3

How Have we come to meet?

How did you hear about the Psychology Support Center?
Family _____ Friend _____ Internet Search _____
Insurance _____ Physician _____ Other _____

In order of importance, what are the top 3 reasons that brought you into therapy?
1. _____
2. _____
3. _____

How have you been coping with your concerns?
_____
_____

Have you ever been in therapy? _____
If yes, with who, how long ago, and was it helpful?
_____
_____

What do you hope to accomplish through therapy? List a few goals.
_____
_____

What do you feel are your strengths?
_____
_____

What do you feel are your weakness?
_____
_____

Section 4

Health & Wellness

How many hours do you sleep at night? _____

Do you exercise? If yes, How often? _____

In the last year, has there been any major changes in your life? (Career, Moving, Marriage, Kids…)

_____
_____
_____

How do manage stress? (Go for walks, meditate, watch tv, read…)

_____
_____
_____

Do you currently, or have you ever received psychiatric care before? If yes, how long ago and with whom?

_____
_____
_____

Do you have any allergies to food, medicine, animals, or environment? If yes, which ones?

_____
_____
_____

Do you take any prescribed or over-the-counter medication? If yes, which ones and what dose?

_____
_____
_____

What are your eating habits?

_____
_____
_____

Section 5

Safety

Have you ever had suicidal thoughts? If yes, please explain further:

_____
_____

Have you ever planned to hurt yourself? If yes, please explain further:

_____
_____

Have you ever tried to hurt yourself? If yes, please explain further:

_____
_____

Have you ever seriously harmed another? If yes, please explain further:

_____
_____

Do you own a weapon? _____

Have you ever been involved, or witnessed a traumatic event? If yes, please explain further:

_____
_____

Are you currently involved in a legal issue that requires you to seek therapy? If yes, please explain further:

_____
_____

Section 6

Family Dynamic

Parent's marital status: *Please circle one*
Married Divorced Never Married Separated Widowed Domestic Partners

What is your relationship with your parents?

_____
_____

Who do you currently live with?

_____
_____

Do you have any pets? If yes, what are their names and types?

_____
_____

GENOGRAM

Section 7

Intimacy and Relationships

Intimacy

Are you currently in a relationship? If yes, describe your relationship?

_____
_____
_____

How would you describe the intimacy of your relationship?

_____
_____
_____

What do you like most about your relationship?

_____
_____
_____

What do you dislike most about your relationship?

_____
_____
_____

Relationships

Describe your relationship with your friends?

_____
_____

What are your support systems? (family, friends, religious affiliations, groups…)

_____
_____

Do you belong to religious or spiritual groups? If yes, how do they affect your life?

_____
_____

Is there anything else you would like us to know about yourself?

_____
_____