Transitions Professional Center, LLC

Psychologists Specializing in Health, Rehabilitation, Palliative Care & Bereavement

Adult Intake Form

Background Information

Name: _____ DOB: _____ Age: _____ Gender:_____

Racial/ethnic background: _____

Address: _____

Home phone: _____ May we leave a message? Yes / No

Cell/Other phone: _____ May we leave a message? Yes / No

Email: _____ May we send emails to you? Yes / No

*Please remember we **cannot** guarantee that email correspondence will be confidential.

Who referred you to this clinic? _____

Emergency contact (name & phone #): _____

Chief Concern

Please describe the main difficulty that has brought you to see me:

Health History

Who is your primary care provider? _____

Clinic name: _____

Phone: _____ Fax number: _____

Address: _____

Current and past health conditions:

_____

_____

_____

_____

On a scale of 0 (no pain) to 10 (worst pain imaginable), how would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

On the same scale, how would you rate your USUAL level of pain during the last week?

0 1 2 3 4 5 6 7 8 9 10

On the same scale, how would you rate your BEST level of pain during the last week?

0 1 2 3 4 5 6 7 8 9 10

On the same scale, how would you rate your WORST level of pain during the last week?

0 1 2 3 4 5 6 7 8 9 10

Are you currently experiencing any violence or abuse in your home? Yes / No

Have you ever been diagnosed with a psychiatric or mental health condition? Yes / No Unknown

If yes, which condition(s)? _____

Have you ever received psychological, drug or alcohol treatment, or counseling services? Yes / No

Please indicate which type of treatment (circle one): Inpatient Outpatient Both

If yes, please indicate <u>current</u> or <u>most recent</u> counseling services:

When: _____ For What: _____

From Whom: _____

Results:

_____

_____

<u>Social Background/Family History</u>

Where were you born? _____

Where did you grow up? _____

What is your current living situation? _____

Current relationship status?: married never married/single widowed living with partner divorced

What is your spouse's/significant other's name: _____

Children (please list name(s) & age(s)): _____

_____

Number of grandchildren: _____ Number of great-grandchildren: _____

Significant people/organizations in your life (e.g., family members, friends):

_____

_____

What, if any, religion or spiritual tradition(s) do you follow? _____

To the best of your knowledge, has any blood relative suffered from the following:

Bipolar (manic-depressive) Disorder?	Yes / No	Obsessive-Compulsive Disorder?	Yes / No
Schizophrenia?	Yes / No	Dementia/Alzheimer's?	Yes / No
Alcoholism?	Yes / No	Attention-Deficit Disorder?	Yes / No
Problems with Drugs?	Yes / No	Suicide (or attempt)?	Yes / No

Occupational/Educational Background

Are you currently working? Yes / No If not, when did you last work? _____

Current or primary lifetime occupation: _____

Years of education: _____

Military Service Branch: _____ Year enlisted: _____ Year discharged: _____

Honorable Discharge? Yes / No

Other

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? (Use the back of the form if needed)