South Coast Psychological Services

Adult Intake Form

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Informed Consent Form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer." Please bring it with you to the first session.

DATE: _____ **REFERRAL SOURCE:** _____

NAME: _____
Last First Middle

DATE OF BIRTH: _____ **BIRTHPLACE:** _____**AGE:** _____

ADDRESS: _____

TELEPHONE: H: _____ Cell: _____Work _____
Please mark your preferred contact number

EMAIL: _____
Please do not indicate an email address if you do not wish to be contacted by email

PERSON & TELEPHONE NO. TO CONTACT IN EMERGENCY:

Name: _____ TELEPHONE NO: _____

PRESENTING PROBLEM (be as specific as you can: when did it start, how does it affect you.):

_____

_____

_____

_____

_____

Estimate the severity of above problem: Mild ____ Moderate ____Severe ____Very severe ____

HIGHEST GRADE: _____ **TYPE OF DEGREE:** _____

OCCUPATION (former, if retired): _____

_____

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CURRENT MARITAL STATUS: _____

MARITAL HISTORY (engagements, marriages, divorces, widowhood): _____

_____

_____

_____

PERSONS LIVING AT HOME WITH YOU: _____

_____ _____

_____ _____

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person.)

1. _____
2. _____
3. _____
4. _____
5. _____

PARENTS/STEPPARENTS (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship.):

Father: _____

_____

_____

Mother: _____

_____

_____

Step-parents: _____

_____

_____

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SIBLINGS (name/age, if deceased: age and cause of death & brief statement about the relationship.):

1. _____
2. _____
3. _____
4. _____
5. _____

DESCRIBE YOUR CHILDHOOD IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral problems, abusive/alcoholic parent):

_____

_____

_____

_____

_____

What gives you the most joy or pleasure in your life?

_____

_____

What are you main worries and fears?

_____

_____

What are your most important hopes or dreams?

_____

_____

MEDICAL DOCTOR (S) (name/phone): _____

_____

_____

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PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness, etc.):

Current: _____

_____

_____

Past: _____

_____

_____

CURRENT MEDICATION (doses and reasons for taking them):

_____

_____

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family: e.g. cancer, epilepsy, etc.):

_____

_____

_____

FAMILY HISTORY OF PSYCHIATRIC ISSUES

☐ Mood Disorder ☐ Anxiety ☐ Substance Abuse ☐ Psychotic Disorder

☐ Developmental Disorder ☐ Domestic Violence ☐ Physical Abuse ☐ Sexual Abuse

☐ Chaos/Instability ☐ Trauma ☐ Abandonment ☐ Other

Please explain below:

_____

_____

_____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments):

_____

_____

_____

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SUICIDE ATTEMPT/S or VIOLENT BEHAVIOR (describe: ages, reasons, circumstances, how, etc.)

_____

_____

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY: (describe quality, frequency, activities, etc.)

_____

_____

PAST/PRESENT PSYCHOTHERAPY or HOSPITALIZATIONS (specify: month year(s) (beginning—end), estimated no. of sessions, name, degree, reason for therapy, Individual/Couple/Family):

1. _____

_____

_____

2. _____

_____

_____

3. *USE OTHER SIDE OF PAGE TO ADD MORE INFORMATION ABOUT PSYCHOTHERAPISTS, IF NEEDED.*

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if you answer Yes, please explain):

_____

_____

Please add, on the other side of the page or on a separate page, any other information you would like me to know about you and your situation.

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