Case No. ______________
Referred By ________________

CONFIDENTIAL
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Adult Intake Information Form

CLIENT INFORMATION

Name: ____ Date: ________________

Social Security Number: __________________________

Email Address: _________________________________

Address: ____

____

Phone: Home _(____)________________ Cell _(____)________________ Work _(____)________

Which number is best to contact you? _______________________ Can I leave a message? Yes No

Gender: M F Relationship status: ________________________

If you are Partnered or Married, how long have you been in this relationship? _______________

Age: ______________ Birthdate: _______________

Highest grade/degree completed in school/college: _____________

Are you a veteran? Yes No If so, branch and years of service: _______

Occupation: _________________________________ Employer: ______________________________

Income: less than $20,000 $20-40,000 $40-60,000 $60-$100,000 more than$100,000

INSURANCE INFORMATION

PRIMARY INSURANCE:	Policy Holder's Name:
Claims Address:	Relationship to Client
City/StatelZip	I.D.#:
Claims Phone #:	Group#:
SECONDARY INSURANCE:	Policy Holder's Name:
Claims Address:	Relationship to Client
City/SlateJZip	I.D. #:
Claims Phone #:	Group #:

Please list all of the members of your household

Name	Relationship	Employment/School	Age

Additional People in your life who play an important role

____

____

____

PRESENTING CONCERNS

Briefly describe your reason(s) for seeking help:

____

____

____

How long have you experienced this?______________________________

How severe are your symptoms? Mild Moderate Severe

How have you attempted to resolve these concerns?______________________________

Have you been treated by other mental health professionals? Yes No

If so, when and for how long?

____

_Are you taking any medications for this concern? Yes No

If so, list medications:

____

____

What are your goals for counseling (do not answer this question if you came for testing) ?

____

____

____

____

CURRENT HEALTH

Primary Care Physician: _________________________________ Phone: _(___)___________________________

Height: _____________________ Weight: ________________________

How would you rate your physical health? Poor Average Good

Do you have any specific medical conditions that concern you? Yes No If yes, describe:

____

____

Have you received treatment for these conditions? Yes No

Do you have problems sleeping? Yes No

If so, what types of problems? Difficulty falling asleep Wake often Poor Sleep Habits

Other:___________________________________

Have you experienced any recent changes in your appetite? Yes No

Have you ever had concerns about having an eating disorder? Yes No

How often do you exercise? Very Little 1-2 times a week 3-4 times a week Daily

What type(s) of exercise do you engage in? __________________________________

How would you rate your alcohol consumption? None Light Moderate Heavy

Do you ever consume more than 5 drinks in one setting? Yes No How often? ____________________

Do you use other recreational or illegal drugs? Yes No

What do you do for fun or for relaxation? ____

How would you rate your social life? Poor Average Good

Please circle items of concern to you:

Anxiety/Nervousness

Shyness

Social Problems

Stress

Anger

Explosive temper

Low Energy

High Energy

Unhappy most of the time

Cry too often

Sadness

Difficulties concentrating
Loneliness

Low self confidence

Low self esteem

Fear making mistakes

Thoughts of cutting or burning myself

Obsessive thoughts

Unusual thoughts

Hearing or seeing things that others do not hear or see

Body image

Concerns about my weight

Sexual problems

Sexual identity

Arguments with significant other(s)

Break up of important relationship

Death of a significant other

Death of a pet
Career concerns

Academic concerns

Financial concerns

Legal concerns

Frequent headaches

Frequent stomachaches

Frequent illness
Family member's psychological problems

Family member's alcohol or drug use

Family members suicide

Other concerns:

Do you have thoughts of harming another person?

YES NO

Do you have thoughts of harming or killing yourself?

YES NO

Have you ever attempted suicide?

YES NO

Please describe other health concerns you have:
____

Current medications you are taking:
____

FAMILY AND RELATIONSHIP INFORMATION

Please list members of your immediate family and relationships:

Name(s)	Relationship	Age	Occupation

Have you ever been emotionally or physically abused? YES NO If yes, explain:
____
____
____

Have you ever been sexually abused? YES NO If yes, explain:
____
____
____

Please add any additional information you feel may be useful:
____
____
____

Thank you for providing this information.

Insurance Authorization: I request that payment of authorized insurance company benefits be made on my behalf to New Tampa Psychological Services, Inc. for any services furnished to me or my child by that provider. I authorized any holder of medical information about me or my child to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to/for related services. I understand that my signature requests that payment to the above provider be made and authorized release of medical information necessary to pay the claim.

Signature:____________________________ Date: ________________

Name [Please Print]:____________________________________

The information contained in this self-report was reviewed with the patient.

________________________________ __________________________
Tsila Abush-Kirsh, Ph.D. Date
New Tampa Psychological Services, Inc.

This is a strictly confidential patient medical record. Disclosure or transfer is expressly prohibited by law.