ASSOCIATES IN HEALTH PSYCHOLOGY

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GENERAL INTAKE FORM

Name: _____ Date: _____ Phone: _____

Okay to Leave voicemail? Y N

Date of Birth: _____ Age: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Emergency Contact: _____ Phone: _____

1. Legal Sex: (Please check one) ☐ Male ☐ Female

*While Associates in Health Psychology recognizes a number of genders / sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed must be used on documents pertaining to **insurance only**. If your preferred name and pronouns are different from these, please let us know in the space below.*

2. To which cultural or ethnic group, if any, do you identify:

☐ Caucasian ☐ African American ☐ Hispanic

☐ Asian ☐ Native American ☐ Other: _____

3. I am currently ☐ Single ☐ Never Married ☐ Widowed

Please check any that currently apply to you, Even if more than one.

☐ Married for _____ Months / Years

☐ Partnered for _____ Months / Years

☐ Dating for _____ Months / Years

☐ Cohabitating for _____ Months / Years

☐ Separated for _____ Months / Years

☐ Divorced for _____ Months / Years

4. How many children do you have? _____

Please list their age and if they are currently living with you: _____

_____

5. Current Occupation (If retired, what did you do previously)?

_____

Months / Years at current job: _____ Hours Per Week: _____

Do you enjoy your work? ☐ A lot ☐ Moderately ☐ Very Little

Career Goals: _____

6. What brings you to our office today and what outcome do you expect?

_____

_____

_____

_____

_____

_____

7. Primary reason(s) you are seeking services

____ Anger management ____ Anxiety ____ Coping ____ Depression

____ Eating disorder ____ Fear/phobias ____Mental confusion ____Sexual concerns

____ Sleeping problems ____ Addictive behaviors____ Alcohol/drugs

____ Other concerns (please specify): _____

8. Have you ever sought counseling services or been under the care of a psychologist or psychiatrist for any reason?

Date	Duration	Type of Clinician	Was it Helpful?

9. What are your present medical diagnoses? Any surgeries in the past?

_____

_____

_____

10. List all your present medications including dosage and how long you have been taking them (you may also bring in a separate list if you have one):

Medication	Dose	Purpose	Since

11. Social History:

Where were you born and raised? _____

Any Siblings? _____

Who did you live with during your childhood? Mother Father Siblings Other: _____

How would you define your family relationships? _____

_____

_____

Are there any special, unusual, or traumatic circumstances that affected your development? ____ Yes ____No

If yes, please describe: _____

_____

Education Completed: ☐ None, or some elementary ☐ Completed 8th Grade ☐ Some High School

☐ Completed High School or GED ☐ Some College ☐ College Graduate

Typically had? As Bs Cs Ds Fs Did you participate in any sports? _____

Other Training: _____

Special Circumstances (e.g. learning disability, gifted):

_____

Military experience? _____ Yes _____ No Combat experience? _____ Yes _____ No

Where: _____

Branch: _____

Date enlisted: _____ Type of discharge: _____

12. Have you ever been arrested for any reason, or are you involved in any active cases?

____ Yes ____No Are you currently on probation or parole? _____ Yes _____ No

If yes, please describe: _____

Traffic violations: ____ Yes ____ No DUI, DWI: ____ Yes ____ No

Criminal involvement: ____ Yes ____ No Civil involvement: ____ Yes ____ No

If you responded **Yes** to any of the above, please fill in the following information:

Charges	**Date**	**Were you under the influence at the time?** ***(include BAC if applicable)***	**Results**

ALCOHOL Age first used: _____ Date last used: _____

How often did you drink in the past? _____ How much? _____

How often do you currently drink? _____ How much? _____

TOBACCO Age first used: _____ Date last used: _____

How often did you use in the past? _____ How much? _____

How often do you currently use? _____ How much? _____

MARIJUANA Age first used: _____ Date last used: _____

How often did you use in the past? _____ How much? _____

How often do you currently use? _____ How much? _____

METHAMPHETAMINES Age first used: _____ Date last used: _____

How often did you use in the past? _____ How much? _____

How often do you currently use? _____ How much? _____

COCAINE Age first used:_____ Date last used: _____

How often did you use in the past? _____ How much? _____

How often do you currently use? _____ How much? _____

HEROIN Age first used: _____ Date last used: _____

How often did you use in the past? _____ How much? _____

How often do you currently use? _____ How much? _____

HALLUCINOGENS Age first used: _____ Date last used: _____

How often did you use in the past? _____ How much? _____

How often do you currently use? _____ How much? _____

OTHER STREET DRUGS Name of drug(s): _____

Age first used: _____Date last used: _____

How often did you use in the past? _____ How much? _____

How often do you currently use? _____ How much? _____

13. Substance Abuse Questions:

Describe when and where you typically use substances: _____

_____

Describe any changes in your use patterns: _____

_____

Reason(s) for use:

____ Addiction ____ Build confidence ____ Escape ____ Self-medication

____ Socialization ____ Taste ____ Other (specify): _____

How do you believe your substance use affects your life? _____

_____

Who or what has helped you in stopping or limiting your use? _____

_____

Does or has someone in your family have a problem with drugs or alcohol?

____ Yes ____ No If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol?

____ Yes ____ No If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): _____

_____

14. Please check any behaviors or symptoms that occur more often than you would like them to take place:

___ Aggression ___ Elevated mood ___ Phobias/fears ___ Alcohol dependence

___ Fatigue ___ Recurring thoughts ___ Anger ___ Gambling

___ Sexual addiction ___Antisocial behavior ___ Hallucinations ___ Sexual difficulties

___Anxiety ___ Heart palpitations ___ Sick often ___ Avoiding people

___ Sleeping issues ___ Chest pain ___ Hopelessness ___ High blood pressure

___ Speech issues ___ Cyber addiction ___ Impulsivity ___ Suicidal thoughts

___ Depression ___ Irritability ___ Trembling ___ Disorientation

___ Judgment errors ___ Loneliness ___ Distractibility ___ Withdrawing

___ Dizziness ___ Worrying ___ Drug Dependence ___ Mood Shifts

___ Eating Disorder ___ Panic Attacks ___ Memory Impairment

___ Disorganized thoughts ___ Body Image

Other: _____

Any additional information that would assist us in understanding your concerns or problems: _____

_____

_____

_____

_____

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