# Psychology Intake Form

## Patient Information

| First Name | Last Name | Preferred Name | Patient Identifier (If known) |
|---|---|---|---|

| Gender | Preferred Pronouns | Date of Birth | Marital Status |
|---|---|---|---|

| Address | City | State | Zip Code |
|---|---|---|---|

| Email | Preferred Phone Number |
|---|---|

## Emergency Contact

| Full Name | Relationship | Contact Number |
|---|---|---|
| Full Name | Relationship | Contact Number |

## Health and Medical Information

| Primary Care Physician | Address | Contact Number |
|---|---|---|
| Psychiatrist | Address | Contact Number |

Please list any medical conditions

Please list any current medication

## Insurance Information (If Applicable)

| Insurance Carrier | Insurance Plan | Contact Number |
|---|---|---|
| Policy Number | Group Number | Social Security Number |

## Employment Status

☐ Employed ☐ Self Employed ☐ Unemployed ☐ Other ____________

| Occupation | Industry | Company Name |
|---|---|---|

| Company Address | City | State | Zip Code |
|---|---|---|---|

## Availability

Please describe your availability throughout the week

## Patient Information

| First Name | Last Name | Date of Birth | Gender |
|---|---|---|---|
| | | | |

## Personal and Family

What is your ethnicity?

How many people are in your household?

What is your income level?

What is the highest education level you've completed?

| | | |
|---|---|---|
| Have you ever been hospitalized for a psychiatric illness? | ☐ Yes | ☐ No |
| Does any family members have a history of mental illness? | ☐ Yes | ☐ No |
| Have you ever attempted suicide? | ☐ Yes | ☐ No |
| Has any family members ever attempted or committed suicide? | ☐ Yes | ☐ No |
| Do you have problems with substance abuse? | ☐ Yes | ☐ No |
| Does any family members have problems with substance abuse? | ☐ Yes | ☐ No |
| Have you ever been arrested?<br>If yes, please explain: | ☐ Yes | ☐ No |

How are you doing at your job?

☐ I. Not working ☐ II. Cannot Function ☐ III. Serious Problem ☐ IV. Mild Problem ☐ V. No Problem

How are you doing at in your marital or with your significant other?

☐ I. Not working ☐ II. Cannot Function ☐ III. Serious Problem ☐ IV. Mild Problem ☐ V. No Problem

How are you doing in relationships with family member?

☐ I. Not working ☐ II. Cannot Function ☐ III. Serious Problem ☐ IV. Mild Problem ☐ V. No Problem

How are you doing in relationships with non-family member?

☐ I. Not working ☐ II. Cannot Function ☐ III. Serious Problem ☐ IV. Mild Problem ☐ V. No Problem

How is your overall happiness and well-being?

☐ I. Not working ☐ II. Cannot Function ☐ III. Serious Problem ☐ IV. Mild Problem ☐ V. No Problem

All the answers given to the above questions are answered accurately to the best of my knowledge. I understand that any inaccurate information can be dangerous to my (or patient's) health.

| Parent or Guardian Name (If Applicable) | Relationship to Patient (If Applicable) |
|---|---|
| Signature of Patient, Parent or Guardian | Date |