SELBY PSYCHOLOGICAL SERVICES, PLLC
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# Adult Intake Form

The following information is requested by Selby Psychological Services (SPS) to best serve you. Please clearly print your response to each question. This will help save time in your first session. If you are unable to complete some parts, then leave them blank and you will have a chance to complete them with your psychologist. Case records are strictly confidential.

**SECTION I: IDENTIFYING INFORMATION**

Today's Date: _____

Name_____ Date of Birth_____ Age_____

Address_____ City/State_____ Zip_____

Social Security Number_____ Gender: F___ M___

Home Phone_____ Work Phone_____ E-mail _____

Marital Status_____ Employment_____

Emergency contact_____ Relationship to you_____

Their Home Phone_____ Their Work Phone_____

Who Referred You? _____

If you are Self-Referred, how did you hear about Selby Psychological Services?_____

Primary Care Provider_____ Phone Number_____

Other Mental Health Provider (if any) _____ Phone Number _____

**Insurance Information**

Name of Insured:_____ Gender _____

Insured's Street Address:_____ City/St/Zip_____

Patient's Relationship to Insured:_____ Insured's Birth Date_____

Insured's Social Security #: _____

Name of Insurance Company: _____

Employer and/or Group Number of plan: _____

Insurance ID Number:_____

**SECTION II: DESCRIPTION OF PRESENTING PROBLEM**

Please describe why you decided to seek services at SPS:

Please tell us what you want to work on or change in psychotherapy:

How long has this been a significant problem for you (Please be specific)?

How would you estimate the severity of the problem at this time? (Place "X" on the line below)

Mild---------- Moderate---------- Serious---------- Severe

What symptoms are related to this problem? Please check **all** that apply for you **now**:

| | | | |
|---|---|---|---|
| __overeating | __restless | __rapid heart rate | __compulsive behaviors |
| __taking drugs | __depressed mood | __sweating | __fears/phobias |
| __odd behavior/thoughts | __crying | __trembling or shaking | __anxiety |
| __recent weight gain | __difficulty concentrating | __shortness of breath | __vomiting |
| __recent weight loss | __low motivation | __muscle tension | __distrust |
| __recent appetite changes | __aggressive behavior | __outbursts of temper | __jumpy |
| __social withdrawal | __feelings of worthlessness | __nightmares | __restricting food |
| __suicidal thinking | __impulsive/risky behavior | __easily distracted | __fatigue/loss of energy |
| __dizziness | __sleeping too much | __decreased need for sleep | __obsessions |
| __difficulty falling asleep | __problems at work/school | __financial problems | __relationship problems |
| __difficulty staying asleep | __housing problems | __drinking alcohol | __chronic pain |

__ experienced a traumatic event other: _____

If applicable, please describe any incidents or problems that may have contributed to this problem (e.g., problem with work or school, relationship ending, past trauma, etc.):

In the past, what has been helpful to you in dealing with this problem?

**SECTION III: MEDICAL HISTORY**

Please list any significant past or current health, medical, or psychiatric issues (including anything resulting in hospitalizations).

| Dates | Problem | Treatment | Hospitalization (Y/N) |
|---|---|---|---|
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| | | | |
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| | | | |
| | | | |

Have you ever had treatment by, or are you currently working with a psychiatrist, psychologist, therapist, or counselor?

Yes ___ No ___

If yes, please complete the relevant information below:

| Dates | Problem | Where | Name of Provider | Helpful (Y/N) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
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| | | | | |

Have you ever been given a mental health diagnosis in the past from a mental health professional? Yes____ No____

If yes, as you understand it, what is/was that diagnosis? _____

_____

**(Continue to next page)**

**SECTION IV: MEDICATIONS AND SUBSTANCES USED**

If applicable, please list all **prescription medications** you are now taking or have taken in the past three months, including birth control pills, vitamins, herbs and supplements.

| Medication | Dosage | Prescribing Provider | Length of Prescription | Helpful (Y/N) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |

If applicable, please list all **other non-prescription drugs and/or substances used (illicit or other) not including alcohol.**

| Drug/Substance | Amount Used | Month/Years Using this Drug or Substance | Purpose of using this Drug or Substance |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Consider a typical week during the **past month**. Please fill in a number for each day of the week indicating the typical **number of alcoholic drinks** you usually consume on that day and the **typical number of hours you usually drink on that day.** Please use the key to denote which number represents number of drinks.

| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|---|---|---|---|---|---|---|
| | | | | | | |

1 Drink = 12 oz. beer | 10 oz. microbrew | 8 oz. malt liquor | 4 oz. of wine | 1 oz. of hard alcohol (regular shot glass)

If applicable, how many cigarettes do you smoke per day? _____

If applicable, how many caffeinated beverages do you drink per day? _____

Of what type: Coffee _____ Tea _____ Soda (diet or otherwise) _____

Other_____