# Hamner Psychological Services
# Intake Form-Adult

Please provide the following information:

Client's Full Name:_____
(First) (Middle) (Last)
Nickname:_____ Gender:_____

Today's Date:_____ Age:_____ Birth Date:_____

Street Address:_____ Phone: (home):_____

City:_____State:_____ Phone: (cell):_____

Social Security Number: _____

Emergency Contact: _____

Relationship:_____ Phone:_____

Client was Referred to our office by:_____

Name of Primary Insurance:_____

Name and Birth date of Policy Holder:_____ DOB:_____

Name of Secondary Insurance:_____

Name and Birth date of Policy Holder:_____ DOB:_____

What are the Reasons for Referral or current Problems? (Use back if more space is needed)

1._____

2._____

3._____

4._____

**Medical Care**: (From whom or where do you get your medical care?)

Clinic/Physician's name:

Do you have the Phone number: Y N If yes, it is:

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No

Please list current medical problems:

Are you a Veteran or have any family members that are Veterans? Y N if yes, please describe:

**Legal Issues**: Are you involved in any current legal proceedings? Yes No

Do you have any history of Legal Charges/Arrests?: Yes No if yes, please describe:

**Employment**: Are you currently employed? Y N Other (ie..full time student or retired)

Employer:

Occupation: Length of time with this employer:

**Education History**: (Please describe highest grade completed and where, specialized training or advanced degree)

**Present relationships**:

Name of spouse or partner:

How do you get along with your spouse or partner?

Do you have children: Yes No If No, skip to the next section.

Please list children and ages:

**Past Psychological/Psychiatric Treatment**:

Have you ever received psychological, psychiatric, drug or alcohol treatment, or cousneling services? Yes No

If so, please indicate which type of treatment (circle one): Inpatient Outpatient Both

If yes, please indicate below:

| Agency/Provider Name | When | Reason |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

Have you ever taken medications for psychiatric or emotional problems? Yes No

If yes, please indicate: List on back if more space is needed.

| Name of Medication | When Began | From Whom | For What |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

**List of Symptoms**

Please circle any of the following issues that have been bothering you lately:

| | | | | |
|---|---|---|---|---|
| abuse as child | alcohol use | anger | anxiety | appetite |
| being a parent | career choices | children | compulsions | concentration |
| confidence | depression | divorce | drug use/abuse | eating issues |
| education | energy(hi/low) | extreme fatigue | fears | finances |
| friends | guilt | health issue | insomnia | loneliness |
| making decisions | marriage | negative thoughts | nervousness | nightmares |
| obsessive thinking | overweight | painful thoughts | panic attacks | phobias |
| relationships | sadness | self-esteem | self-harm | separation |
| sexual problems | short temper | social issues/avoidance | | sleep issues |
| stress | suicidal thoughts | work issues | | |

**Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life: Please circle your response.**

**Marriage / Relationship:**

1- No effect 2-Little effect 3-Some effect 4-Much effect 5-Significant effect

Not Applicable

**Family:**

1- No effect 2-Little effect 3-Some effect 4-Much effect 5-Significant effect

Not Applicable

**Job/school performance:**

1- No effect 2-Little effect 3-Some effect 4-Much effect 5-Significant effect

Not Applicable

**Friendships:**

1- No effect 2-Little effect 3-Some effect 4-Much effect 5-Significant effect

Not Applicable

**Financial situation:**

1- No effect 2-Little effect 3-Some effect 4-Much effect 5-Significant effect

Not Applicable

**Physical health:**

1- No effect 2-Little effect 3-Some effect 4-Much effect 5-Significant effect

Not Applicable

**Anxiety level / nerves:**

1- No effect 2-Little effect 3-Some effect 4-Much effect 5-Significant effect

Not Applicable

**Mood:**

1- No effect 2-Little effect 3-Some effect 4-Much effect 5-Significant effect

Not Applicable

**Eating habits:**

1- No effect 2-Little effect 3-Some effect 4-Much effect 5-Significant effect

Not Applicable

**Sleeping habits:**

1- No effect 2-Little effect 3-Some effect 4-Much effect 5-Significant effect

Not Applicable

**Sexual functioning:**

1- No effect 2-Little effect 3-Some effect 4-Much effect 5-Significant effect Not Applicable

**Alcohol / Drug use:**

1- No effect 2-Little effect 3-Some effect 4-Much effect 5-Significant effect Not Applicable

**Ability to concentrate:**

1- No effect 2-Little effect 3-Some effect 4-Much effect 5-Significant effect Not Applicable

**Ability to control anger:**

1- No effect 2-Little effect 3-Some effect 4-Much effect 5-Significant effect Not Applicable

**Substance Use**

Do you currently consume alcohol? Yes No

If yes, on average how many drinks per occasion do you consume?

How many days per week do you consume alcohol?

Do you have a history of problematic use of alcohol? Yes No

Have family members or friends expressed concern about your drinking? Yes No

Do you currently use non-prescribed drugs or street drugs? Yes No

Do you have a history of problematic use of prescription or nonprescription drugs? Yes No

Do you have a family history of alcohol or drug problems? Yes No If yes, please describe:

**Other**

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? Please use the back of form if more room is needed.

Completed by:_____ Date:_____