

Psychology Intake Form

Patient Information					
First Name		Last Name		Preferred Name	
Gender		Preferred Pronouns		Date of Birth	
Address		City		State	
Email		Preferred Phone Number		Zip Code	
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? 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	