Confidential Southeastern Health Psychology Intake Form

Legal Name	______________________________ (First) (Middle) (Last)
Date of Birth	
Social Security Number	
Residential Address	Street:____________________ City: ____________State:__________ Zip Code: ________
Mailing Address	Street:____________________ City: ____________State:__________ Zip Code: ________
Telephone Contact	Home:__________ Work:__________ Cell:__________
How would you identify your sexual orientation?	❑ Straight/Heterosexual ❑Lesbian/Gay/Homosexual ❑Bisexual ❑Transsexual ❑ Asexual ❑ Other:__________
Current Marital Status	❑ Single, not in a relationship ❑ Single, in a relationship ❑ Married for ______ years ❑ Divorced for ______ years ❑ Widowed for ______ years
Spouse/Significant Other's Name	
What is your Spouse/ Significant Other's work status?	❑ Fulltime employment ❑ Part-time employment ❑ Unemployed ❑ Disabled
Have you had any prior marriages?	❑ No ❑ Yes If Yes, how many times have you been married? __________
Do you have children?	❑ No ❑ Yes If Yes, how many children do you have? __________

Please list all the people that you live with.

Name	*Age*	*Relationship*

What City & State were you born in?	
Who was responsible for raising you as a child? (Check all that apply)	❑ Biological Mother ❑ Step Mother ❑ Biological Father ❑ Step Father ❑ Sibling(s) ❑ Uncle ❑ Aunt ❑ Grandmother ❑ Grandfather ❑ Adopted family ❑ Foster family ❑ Other:__________
What was your father's occupation?	
What was your mother's occupation?	
Did your parents' divorce?	❑ No ❑ Yes If Yes, how old were you when they divorced? __________

Please list siblings and ages.

Name	*Age*

Do you have any history of being neglected and/or emotionally, sexually, or physically abuse?	❑ No ❑ Yes If Yes, Please describe when, where, and by whom? ________________________________
What is your highest level of education?	❑ ________Grade ❑ G.E.D. ❑ High School Diploma ❑ Associates Degree ❑ Bachelors Degree ❑ Masters Degree ❑ M.D./D.O ❑ J.D. ❑ Ph.D. ❑ Other: ________________________________
Were you ever held back or failed any grades?	❑ No ❑ Yes If Yes, Please list which grades you failed or repeated:________________________________
Were you ever placed in any remedial or special education classes?	❑ No ❑ Yes If Yes, Please list when you were placed in those classes:____________________________
Have you ever served in the military?	❑ No ❑ Yes If Yes, Please list branch and years of service: ________________________________
Are you currently employed?	❑ No ❑ Yes If Yes, Please list your job title and the name of employer: ____________________________
If you are working, when did you last work?	
If you are working, how many hours do you work per week?	_________ Hours Per week If you have any work restrictions please list them here: ______________________________
Were you ever involved in a work injury and/or motor vehicle accident?	❑ No ❑ Yes If Yes, Please provide specifics: ________________________________
Are you current received Workman's Compensation benefits or Social Security Disability (SSDI)?	❑ No ❑ Yes If Yes, What benefits are you receiving and when did they begin? _____________________
Do you have an attorney who is representing you in a Workman's Compensation, motor vehicle accident, or Social Security Disability (SSDI) claim?	❑ No ❑ Yes If Yes, Please provide the name and address of this attorney: _________________________
Have you ever been convicted of a felony?	❑ No ❑ Yes If Yes, Please provide specifics: ________________________________
Do you have any pending legal problems?	❑ No ❑ Yes If Yes, Please provide specifics: ________________________________

Please list all of your Physicians, Medical Conditions, and Medications/Dosages.	*Physicians*	*Medical Issues*	*Medications/Dosages*

Are you taking any over-the-counter (OTC) medications or nutritional supplements?

❑ No ❑ Yes
If Yes, Please list those OTC medications and/or supplements: ________________________

Are you allergic to any food or medications?

❑ No ❑ Yes
If Yes, Please list all allergies: ________________________

Have there ever been any times that you have not been able to obtain your prescription medications (e.g., problems with authorization, finances) or not taken them as prescribed (e.g., missing dosages, doubling up on dosages) to get a better effect?

❑ No ❑ Yes
If Yes, Please describe what happened:________________________

Have you ever been hospitalized for any medical condition?

❑ No ❑ Yes
If Yes, Please describe the reason for medical hospitalizations and dates: ________________

Have you ever received any previous outpatient mental health care (e.g., psychiatric evaluations, neuropsychological testing, psychotherapy, substance/alcohol abuse counseling)?

❑ No ❑ Yes
If Yes, Please describe the mental health care received and dates: ______________________

Please indicate if you or any family have been hospitalized, diagnosed, and / or treated for any of the following mental health issues.	*Problem*	*Person with the Mental Health Issue*
	❑ Alzheimer Dementia	
	❑ Alcoholism	
	❑ Anger / Violent outbursts	
	❑ Anorexia / Bulimia	
	❑ Anxiety / Panic Attacks / "Nervous Breakdown"	
	❑ Attention-Deficit/Hyperactivity Disorder (ADD/ADHD)	
	❑ Bipolar Disorder	
	❑ Depression	
	❑ Drug Abuse	
	❑ Drug Overdose	
	❑ Hallucinations / Delusional Thinking	
	❑ Inappropriate / Hypersexual Behaviors	
	❑ Obsessive-Compulsive Disorder (OCD)	
	❑ Post-Traumatic Stress Disorder (PTSD)	
	❑ Schizophrenia	
	❑ Suicide Attempt	
	❑ Other:	

Are you currently drinking caffeinated beverages such as coffee, tea, or colas?	❑ No ❑ Yes If Yes, how many drinks do consume in a day? ______________________________
Have you ever smoked cigarettes / cigars / pipes?	❑ No ❑ Yes If Yes, how many cigarettes / cigars / pipes did you smoke in a day? ______________
Are you currently smoking cigarettes / cigars / pipes?	❑ No ❑ Yes If Yes, how many cigarettes / cigars / pipes do smoke in a day? ________________
Have you ever used chewing tobacco?	❑ No ❑ Yes If Yes, how much chew did you use in a day? ______________________________
Are you currently using chewing tobacco?	❑ No ❑ Yes If Yes, how much do you chew in a day? ________________________________
Have you ever drunk alcoholic beverages on a regular basis?	❑ No ❑ Yes If Yes, how much did you drink in a day? ________________________________
Are you currently drinking alcoholic beverages?	❑ No ❑ Yes If Yes, how many drinks in a day? ___________________________________
Have you ever used illicit / street drugs such as marijuana, cocaine, crack, heroin, ecstasy, crank, LSD, speed, inhalants, etc?	❑ No ❑ Yes If Yes, which drugs have you used and for how long? ____________________
Are you currently using illicit / street drugs such as marijuana, cocaine, crack, heroin, ecstasy, crank, LSD, speed, etc?	❑ No ❑ Yes If Yes, which drugs are you using and how much are you using in a day/week?

Please mark the location on the diagram where and what type of pain you are having: **Achy Pain = ^^^^** **Burning = XXXX** **Numbness = 0000** **Pins & Needles = ++++** **Radiating Pain = ////**	*Front*	*Back*
How did your chronic pain start?	______________________________ ______________________________ ______________________________	
On a scale of 0-10 with 0 = no pain and 10 = the worst pain imaginable rate:	_____/10 = Current Pain Levels _____/10 = Weekly Average Pain Levels	_____/10 = Lowest Pain Levels _____/10 = Highest Pain Levels
What makes your pain worse?	______________________________ ______________________________ ______________________________	
What makes your pain better?	______________________________ ______________________________ ______________________________	
Please check off any symptoms you may have experienced over the past month:	❏ Abnormal menstrual cycle / spotting ❏ Abdominal bloating / gas ❏ Anger Outbursts ❏ Body tension ❏ Blackouts ❏ Breathing difficulties ❏ Constipation ❏ Crying Spells ❏ Decreased attention/concentration ❏ Dizziness ❏ Decreased libido (interest in sex) ❏ Depressed mood ❏ Diarrhea ❏ Electrical shock sensation in head/brain ❏ Erectile difficulties ❏ Excessive energy ❏ Excessive guilt ❏ Excessive worry ❏ Excessive sweating ❏ Fatigue / poor energy ❏ Flashbacks of traumatic events ❏ Feelings of internal restlessness ❏ Forgetfulness ❏ Grandiose thoughts ❏ Hallucinations	❏ Hot flashes ❏ Hopelessness/Helplessness ❏ Impulsivity ❏ Inability to enjoy activities ❏ Increased irritability ❏ Increase risky behavior ❏ Increased libido (interest in sex) ❏ Inability to express emotion ❏ Loss of interest ❏ Muscle soreness ❏ Panic attacks ❏ Racing/erratic heartbeat ❏ Racing thoughts ❏ Repetitive cleaning/organizing/counting ❏ Ringing in ears ❏ Seizures ❏ Shaking (hands, feet, whole body) ❏ Skin rashes ❏ Social avoidance ❏ Spending Sprees ❏ Suspiciousness ❏ Thoughts of killing oneself ❏ Thoughts of killing another person ❏ Unexplained lapses of time ❏ Vision changes (blurry, double vision, etc.)

Have you experienced any recent changes in your appetite?	❑ No ❑ Yes -- If Yes, which have you experienced: ❑ No appetite ❑ Decreased appetite ❑ Increased appetite ❑ Increased cravings for certain foods ❑ Nausea/Vomiting when eating or thinking of food ❑ Other: ____________
Have you experienced any recent changes in your weight?	❑ No ❑ Yes -- If Yes, which have you experienced: ❑ Weight gain of ________ lbs. in _______ months ❑ Weight loss of ________ lbs. in _______ months ❑ Other:____________
Have you experienced any recent changes in your sleep habits?	❑ No ❑ Yes -- If Yes, which have you experienced: ❑ Difficulty getting to sleep ❑ Difficulty staying asleep ❑ Waking up earlier than normal ❑ Night Sweats ❑ Restless sleeping ❑ Daytime sleepiness ❑ Daytime napping ❑ Nightmares ❑ Other: ____________
Do you need any help walking or getting from place to place?	❑ No ❑ Yes -- If Yes, what type of help do you need and who helps you? ____________
Do you need any help bathing, grooming, or dressing yourself?	❑ No ❑ Yes -- If Yes, what type of help do you need and who helps you? ____________
Do you need any help preparing meals for yourself?	❑ No ❑ Yes -- If Yes, what type of help do you need and who helps you? ____________
Do you need any help cleaning your residence?	❑ No ❑ Yes -- If Yes, what type of help do you need and who helps you? ____________
Do you need any help doing your laundry?	❑ No ❑ Yes -- If Yes, what type of help do you need and who helps you? ____________
Do you need any help paying your bills or managing your finances?	❑ No ❑ Yes -- If Yes, what type of help do you need and who helps you? ____________
Do you need any help getting, organizing, or taking your medications?	❑ No ❑ Yes -- If Yes, what type of help do you need and who helps you? ____________
Do you need any help with shopping?	❑ No ❑ Yes -- If Yes, what type of help do you need and who helps you? ____________
Do you need any help caring for others who live with you such as children, medically ill spouses, or parents?	❑ No ❑ Yes -- If Yes, what type of help do you need and who helps you? ____________
If you are working, do you need any help doing your job?	❑ No ❑ Yes -- If Yes, what type of help do you need and who helps you? ____________

Certification of Accuracy

I certify that the answers provided in this 6 page Confidential Southeastern Health Psychology Intake Form are accurate to the best of my knowledge.

____________________ ____________________
Patient's Signature Date

____________________ ____________________
Signature of Legal Guardian Date