Marlton Psychological Services

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Intake Form

Personal Information

Date: ________________

Last Name: _________________ First Name:_________________ M.I.: ________
Age: ___ Date of Birth: _________ Gender: ___ Social Security #: ___________

Street Address:____
City: ___________________________ State: _____ Zip code: ________________
Ok to send mail: _____ If no, please provide alternate address:_______________
____

Home phone: ___________________________ Ok to leave a message: _____
Cell phone: _____________________________ Ok to leave a message: _____
Ok to text message: ______
Work phone: ____________________________ Ok to leave a message: _____
Email Address: ___________________________

Emergency contact: ________________ Relationship to you: _______________
Address: ____
Home Phone: __________________ Cell/Work Phone: ______________________

Referral Source (how you heard about counseling services):
____

Insurance Information
Insurance Provider: __________________________

Policy Number: __________________ Group Number: _______________

Member Services Telephone Number:_____________________________

Office Visit Co-Pay: ________ Specialist Co-Pay: ________

Name of Insured (If different from yourself): ___________________________

Primary Insured's Date of Birth: __________________

Employer of Primary Insured: ______________________________________

I agree to pay for any services not covered by the above listed insurance provider (Please Sign and Date): ____

Health Information
Please answer the following questions using: 5 = Excellent, 4 = Good, 3 = Average, 2 = Poor, 1 = Failing

How would you currently rate your mental health: _____
How would you currently rate your physical health: _____

Mental Health Information
Briefly describe why you are coming in for counseling and the goals you hope to achieve in therapy:
____
____
____
____
____
____

Have you ever been in counseling/therapy before?: _____ If yes when and with whom?:
____
____
____

Was previous counseling helpful or effective?: ______ If not, please explain:
____
____
____

Are you currently receiving mental health services?: _____ If yes, please list name of practitioner and type of services you are receiving:_________________
____

Have you ever been hospitalized for mental health concerns?: _____ If yes, list date(s) and length of stay:____
____
____
____

Have you ever been diagnosed with a mental illness?: ______ If yes, please list and provide date first diagnosed:

____
____
____
____

Has anyone in your family ever been diagnosed with a mental illness? If yes, please list relationship and illness:

____
____
____
____

Have you ever engaged in self harm? Currently: _____ Past: _____
Have you ever contemplated suicide? Currently: _____ Past: _____
Have you ever contemplated harming another person? Currently: ___ Past: ___
Have you ever attempted suicide?: _____ If yes please list date(s), method(s), and your age at time of attempt:

____
____
____
____

Has any one in your family ever attempted suicide?: _____ If yes please list relationship: ______________

Has any one in your family ever completed suicide?: _____ If yes please list relationship: ______________

Has any one else in your life ever attempted _____ or completed suicide?: _____ If yes please list relationship: ______________

Have you ever had trouble sleeping?: _____ If yes, please describe:

____
____
____
____

Have you ever had problems with eating or with food?: _____ If yes, please describe:

____
____
____
____

Medical Information
Do you now have, or have you had in the past, any of the following? Check all that apply:

	Now	Past		Now	Past		Now	Past
Asthma			Allergies			Headaches		
Brain Injury			Epilepsy			Seizures		
Digestive Disorders			Cancer			Diabetes		
Breathing Problems			Immune System Problems			Heart Disease		
High Blood Pressure			Vision Problems			Hearing Problems		
Arthritis			Urinary Disorders			Tuberculosis		
Thyroid Disorder			Multiple Sclerosis			Chronic Fatigue Syndrome		
Fibromyalgia			Pregnancy (how many)			Miscarriage (how many)		
Abortion (how many)			Sexually Transmitted Disease			Sleep Disorder		
Serious Accident			Surgery			Other		

Currently under the care of a Doctor or other medical health professional?: _____

Primary Care Physician: _____________________Phone #: _______________
Address: ____

Name of Specialist Physician: ________________ Phone#: _______________
Address: ____

Please list any prescription medications you are currently taking:
____
____

____
____

Please list any over the counter medications, vitamins, or herbal supplements you are currently taking:
____
____
____
____

Do you currently exercise?: _____ Please describe: ________________________
____

How many times per week do you exercise?: _____

Substance Abuse Information
Please indicate substances currently used (over the past 6 months), how much at one time, how many times per day/week, age of first use, past use history, and length of time used.

Substance	**Currently?**	**Amount**	**Frequency**	**Age first used**	**Past Use**	**How Long?**
Caffeine						
Alcohol						
Tobacco						
Marijuana						
Ecstasy						
Cocaine/Crack						
Heroin						
Heroin						
Methamphetamines						
PCP/LSD/Mushrooms						
Pain Killers						
Steroids						
Tranquilizers						
Sleeping Pills						
Diet Pills						
Other:						

Have you ever believed your substance use was a problem for you?: __________
Has anyone ever told you they believed your substance use was a problem?: __________

Have you ever had withdrawal symptoms when trying to stop using any substances?: __________

Have you ever had problems with work, relationships, health, the law, etc. due to your substance use?: __________If yes, please describe: ____________________
____
____

Have you ever participated in drug and alcohol treatment?: _____ If yes, please list type, length, dates, and age when you received these services:
____
____
____

Have you ever attended Alcoholics or Narcotics Anonymous?: _____ If yes, please list length of time sober and number of meetings you attend per week:
____
____

Spiritual Information

What is your religion/ spiritual beliefs?: _____________________________________
____
____

How important are your religious/ spiritual beliefs to you?: ____________________
____

Do you currently belong to a faith community (church, synagogue, temple, religious order, etc.?: _____ If yes, please describe your current level of connection and involvement:____
____
____
____

Do you want to incorporate your faith/spirituality into the counseling process?:____ If yes, please describe how you would like to do so, and if you are specifically seeking faith based counseling?:________________________________
____
____
____

Relationship Information

Are you currently in a relationship?: _____ If yes, please describe: ___________
____

Name of person: _______________________ Length of relationship: ________
Do you currently live together?: _____

Number of marriages: _______ Number of divorces: _______
If widowed, your age at death of spouse: ____

If you are currently experiencing relationship difficulties you would like to address in counseling, please briefly describe: __________________________________
____
____
____
____

Do you have children?: _____ If yes, please list below:

Name	Age	Lives with you?	Name	Age	Lives with you?

Other persons living in your household and your relationship to them:
____
____
____
____

Family Information
Were you adopted?: _____ If yes, your age at time of adoption: _____
With whom did you live until the age of 18: ______________________________
____

Did your parents ever divorce?: _____ If yes, your age at time of divorce: _____
If divorced, did your parents ever re-marry?: _____ If yes, list parent(s) and your age(s) at time of remarriage:
____
____
____

____
____

Were you ever in foster care or residential care?: _____ If yes, please list age and living situation:

____
____
____
____

Please provide your mother's name, age, occupation, and overall health: ______
____

Please provide your father's name, age, occupation, and overall health: ______
____

Do you have siblings?: _____ If yes, please list names, ages, and relationship:

Name	Age	Quality of your relationship with sibling

Have you ever experienced the death of a family member or a close friend?: ___ If yes please describe and list your age at time of their death: _______________
____
____

Please indicate if you or a member of your immediate family experienced any of the following. If a family member, please indicate relationship(s):

	Self	Other	Relationship		Self	Other	Relationship
Emotional Abuse				Legal Problems			
Physical Abuse				Frequent/Multiple Moves			
Sexual Abuse				Homelessness			
Domestic Violence				Financial Problems			
Neglect				Lived overseas			
Substance Abuse				Military member			
Serious Illness				Discrimination			
Accident or Injury				Other			

Educational Information

Number of years of education completed: _____
Degree(s) achieved (please mark all that apply):

High School Diploma		GED		Vocational/Trade School Certificate		Associates Degree	
Bachelors Degree		Masters Degree		Doctorate		Other	

Vocational Information
Are you currently employed: _____ If yes, please list position title, name of employer, type of work, and length of employment: _______________________
____
____

If not currently working, how long un-employed?:__________________________

What types of jobs have you typically held?: _____________________________

What is the longest period of time you have ever worked at one job?:__________

Are you currently considering a change in job or career?: _____ If yes, what type of work are you interested in doing?: ___________________________________
____

Have you ever served in the military?: _____ If yes, please list branch, rank, and current status(active/discharged): ______________________________________
____

If deployed please list dates and locations:______________________________
____
____
____

Please list your personal hobbies and interests:
____
____
____
____
____

Legal Information

Have you ever been the victim of a crime?:_____ If yes, please list date and briefly describe: ____
____
____
____

Are you currently involved in divorce or child custody proceedings?: _____ If yes, please explain: ____
____
____
____

Have you ever been convicted of a misdemeanor or felony?: _____ If yes, please explain:____ ____________
____
____
____
____
____