ROSE CITY GEROPSYCHOLOGY, LLC
ADULT INTAKE FORM

Background Information

Name: _____ DOB: _____ Age: _____ Gender:_____

Racial/ethnic background: _____

Address: _____

Home phone: _____ May we leave a message? Yes / No

Cell/Other phone: _____ May we leave a message? Yes / No

E-mail: _____ May we send e-mails to you? Yes / No

*Please remember we **cannot** guarantee that e-mail correspondence will be confidential.

How would you like to be reminded of scheduled appointments? Phone / Text / E-Mail / None

*Appointment reminders are generated from our EHR and will be sent from 650-215-6211 and appointmentreminders@therapyportal.com

Who referred you to this clinic? _____

Emergency contact (name & phone #): _____

Reason(s) for Seeking Therapy

What 2 to 3 things do you hope to accomplish through our work together? That is, what would you like to be doing differently by the time our work is finished?

Physical and Emotional Health History

Who is your primary care provider? _____

Clinic name: _____

Phone: _____ Fax number: _____

Address: _____

What are your current and past health conditions?

_____

_____

_____

*Please remember to bring a list of your current medications and supplements. If none, initial here: _____

On a scale of 0 (no pain) to 10 (worst pain imaginable), how would you rate your physical pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

On the same scale, how would you rate your USUAL level of physical pain during the last week?

0 1 2 3 4 5 6 7 8 9 10

On the same scale, how would you rate your BEST level of physical pain during the last week?

0 1 2 3 4 5 6 7 8 9 10

On the same scale, how would you rate your WORST level of physical pain during the last week?

0 1 2 3 4 5 6 7 8 9 10

Have you ever been diagnosed with a psychiatric, mental health, or emotional condition, including depression and anxiety? Yes / No Unknown

If yes, which condition(s)? _____

Have you ever received psychological, drug or alcohol treatment, or counseling services? Yes / No

Please indicate which type of treatment (circle one): Inpatient Outpatient Both

Do you now, or have you ever, taken medication for a psychiatric, mental health, or emotional condition, including depression and anxiety? Yes / No Unknown

If yes, please list the name and contact information for your prescribing healthcare provider:

_____

How often do you have a drink containing alcohol, including beer and wine? _____

Do you currently use any type of tobacco? Yes / No

Do you currently use any type of recreational drug, including marijuana? Yes / No

Social Background/Family History

Where were you born? _____

Where did you grow up? _____

What is your current living situation? _____

Are you currently experiencing any violence or abuse in your home? Yes / No

Current relationship status?: married never married/single widowed living with partner divorced

What is your spouse's/significant other's name: _____

Children (please list name(s) & age(s)): _____

_____

Number of grandchildren: _____ Number of great-grandchildren: _____

Significant people/organizations in your life (e.g., family members, friends, communities):

_____

_____

What, if any, religion or spiritual tradition(s) do you follow? _____

Do you have any history with the legal system (e.g., arrest, DUI, incarceration, litigation)? Yes / No

To the best of your knowledge, has any blood relative suffered from the following:

Bipolar (manic-depressive) Disorder?	Yes / No	Obsessive-Compulsive Disorder?	Yes / No
Schizophrenia?	Yes / No	Dementia/Alzheimer's?	Yes / No
Alcoholism?	Yes / No	Attention-Deficit Disorder?	Yes / No
Problems with Drugs?	Yes / No	Suicide (or attempt)?	Yes / No

Occupational/Educational Background

Are you currently working? Yes / No If not, when did you last work? _____

Current or primary lifetime occupation: _____

Years of education: _____

Military Service Branch: _____ Year enlisted: _____ Year discharged: _____

Honorable Discharge? Yes / No

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? (Use the back of the form if needed)