HIGH PLAINS PSYCHOLOGICAL ASSESSMENT CENTER
1920 Thomes Avenue, Suite 500
Cheyenne, WY 82001
307-640-7720

ADULT INTAKE FORM

GENERAL INFORMATION

Please provide the following information and answer the questions. Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Name:_____ Preferred Name: _____

Your age: _____ Date of Birth (DOB):_____ Today's Date: _____

Gender Identity: _____ Pronouns: _____

Languages Spoken: _____ Preferred Language: _____

Address:_____

_____

Spouse or Partner's Name (if applicable): _____

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

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

Work phone: _____ May we leave a message? Yes No

Email: _____ May we email you? Yes No

May we send you text message appointment reminders? Yes No Phone for texts: _____

Who referred you to High Plains? Please provide agency/professional's name:

_____

What are the main reasons you're seeking an evaluation/treatment? (Please include how long you've had these symptoms or problems): _____

_____

_____

_____

What made you come in at this time? _____

_____

_____

_____

What do you hope to gain from this evaluation/treatment?_____

_____

_____

_____

SYMPTOMS:

How much are each of the following areas currently a problem for you?

	Not at all 1	A little 2	Somewhat 3	Significantly 4
Anxiety	1	2	3	4
Fear of Certain Objects/Situations	1	2	3	4
Repetitive Behaviors or Mental Acts	1	2	3	4
Avoiding Certain Things/Places	1	2	3	4
Panic Attacks	1	2	3	4
Intrusive Memories	1	2	3	4
Irritability	1	2	3	4
Physical Problems	1	2	3	4
Sleep Problems	1	2	3	4
Changes in Eating/Appetite	1	2	3	4
Depression	1	2	3	4
Worthlessness	1	2	3	4
Hopelessness	1	2	3	4
Self-harm/Suicidal Thoughts	1	2	3	4
Inappropriate Expression of Anger	1	2	3	4
Difficulty Meeting Expectations	1	2	3	4
Difficulty Problem-solving	1	2	3	4
Memory Problems	1	2	3	4
Alcohol or Substance Abuse	1	2	3	4
Family Conflicts	1	2	3	4
Marital Conflicts	1	2	3	4
Social Relationships	1	2	3	4
Social Withdrawal	1	2	3	4
Job/School	1	2	3	4
Sexual Problems	1	2	3	4
Legal Problems	1	2	3	4
Abuse (physical, emotional, sexual)	1	2	3	4

Please describe any other symptoms or experiences you have had problems with (not listed above).

Have you experienced any unusually severe stresses during the last year? Yes No
If yes, please describe:

What do you consider to be your strengths?

What do you consider to be your areas of needed growth?

HEALTH & MENTAL HEALTH INFORMATION

Do you currently have any medical problems?

Have you ever been diagnosed with any of the following? If so please circle and describe:
Head injury, strokes, seizures, fainting, loss of consciousness, neurologic conditions (Multiple sclerosis, Parkinson's), cancer, headaches, diabetes/kidney, allergies, chronic fatigue, high fevers, surgeries, any other conditions:

Have you previously seen a therapist or psychiatrist? If so, what year? Who did you see and for what reason? Approximately how many meetings did you have? Was the experience helpful or not? How so?

Have you ever been hospitalized for medical or mental illness? If so, list when, where, & reason:

Have you ever attempted suicide? Yes ____ No ____

Have you ever engaged in self-harming behaviors? Yes _____ No ____

If yes, please describe:

Please list current prescription medications with dosage (psychiatric and general health):

Please list any previous psychiatric medications (with dosage and dates):

Who is your primary care physician?

Who is your psychiatrist (if applicable)?

When was your last complete physical exam (month/year)?

How many times a week do you exercise? What type and how many minutes?

Do you drink alcohol or use recreational drugs? If so, what kind and how often?

Do you or anyone close to you consider your use to be a problem? Yes No

Please indicate for each substance listed below

Substance	Ever Used?	Age at 1st Use	Time Since Last Use	Approx. Use in last 30 days
Alcohol				
Marijuana				
Cocaine/Crack				
Heroin				
Methamphetamine				
Ecstasy				
Hallucinogens				
Other Drugs				

Personal and Educational History

Where were you born?

Where did you live most of your childhood?

What was the highest level of education you completed?

Did you receive any special accommodations in school (Individualized Education Program, 504 Plan, informal supports)?

When you were a child, did you struggle with any of the following: Age

Learning disabilities/Poor grades	Yes	No	_____
Inattention	Yes	No	_____
Hyperactivity	Yes	No	_____
Behavior Problems	Yes	No	_____
Bed wetting	Yes	No	_____
School fears	Yes	No	_____
Social Problems	Yes	No	_____
Teasing/Bullying	Yes	No	_____
Eating disorders	Yes	No	_____
Witnessing violence in the home	Yes	No	_____
Sexual, physical or emotional abuse	Yes	No	_____

If so, at what age and by whom? _____

YOUR FAMILY GROWING UP (Family of Origin)

	MOTHER	**FATHER**
Current age, or if deceased date, age, and cause of death		
Country of Origin		
Religious/Spiritual Affiliation (if any)		
Use 3 adjectives or more to describe <u>each</u> parent		
How did you and <u>each</u> parent get along when you were growing up? Give some examples of things that you did together & feelings you had.		
Use 3 adjectives or more to describe your parents' relationship		
How did your parents get along?		
Years married or together		
If divorced or not together, your age at divorce		
Reason for divorce/split		
Describe your relationship with step-parents (if any)		
List anyone else who lived with you <u>or</u> regularly cared for you		
Were you adopted? Age?	**If so, please write any relevant information about your biological parents.**	
List any major problems in your family growing up:		

Siblings

Please list all of your brothers and sisters in the order of birth.

First name	Biological (Yes/No)	Current Age	Male/ Female	Married or Partnered? (Yes/No)	Describe your relationship in a few words

FAMILY MENTAL HEALTH HISTORY

In the section below identify if any members of your family and extended family have a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please circle		List Family Member(s)
Anxiety (general)	Yes	No	_____
Obsessive Compulsive Disorder	Yes	No	_____
Depression	Yes	No	_____
Suicide Attempts	Yes	No	_____
Bipolar/Manic Depressive	Yes	No	_____
Learning Difficulties	Yes	No	_____
Attention-Deficit/Hyperactivity Disorder	Yes	No	_____
Autism Spectrum Disorder	Yes	No	_____
Alcoholism/Substance Abuse	Yes	No	_____
Domestic Violence	Yes	No	_____
Eating Disorders	Yes	No	_____
Schizophrenia	Yes	No	_____
Psychiatric Hospitalizations	Yes	No	_____

CURRENT FAMILY, SOCIAL SUPPORTS, OCCUPATION & LIFE INTERESTS/ACTIVITIES

Intimate Relationships & Social Supports

Sexual Orientation: Heterosexual ___Homosexual ____Bisexual ____Pansexual ____Asexual _____

Other _____I choose not to answer _____

Have you been married previously? _____If yes, please describe: _____

_____

_____

Are you currently married? Yes_____No _____ How long?_____

Are you currently partnered/in a romantic relationship? Yes _____ No _____How long? _____

Do you have any concerns about your current marital or romantic relationship that you would like to discuss? If so, what are they?

Are you currently separated or divorced? Yes _____No _____ How long? _____

If you and your former spouse/partner have children together, please describe your current custody & visitation schedule (if any) and the status of your communication:

Please describe your social relationships. Do you have friends and/or extended family? Go out for fun? Socialize? Whom can you turn to for emotional and other forms of support?

Children

Please list your biological, adopted and/or stepchildren (if applicable)

First name	Biological, Adopted or Step	Current Age	School grade?	Male/ Female	Lives with you? (Yes/No)	Describe your relationship in a few words

Employment and/or Current Educational Situation

Are you currently employed? Yes _____ No _____

Are you currently a student? Yes _____No_____

Please describe your current work or academic situation: _____

Do you enjoy your work/school? Is there anything stressful about it? _____

Have you ever been arrested? _____If yes, please describe. _____

Interests/Activities/Spirituality

What are some of your interests & activities? _____

_____

_____

Do you consider yourself spiritual or religious? Yes ___ No ____I choose not to answer _____

If so, describe your spirituality/faith and your level of participation in a faith-based group (if applicable):

_____

Is there any other information you would like us to know about you? _____

_____

_____