HYLAND PSYCHOLOGICAL SERVICES, INC
INTAKE FORM

Today's date: ____/____/____

***Please complete all questions on this form (Please Print)**

CLIENT INFORMATION

Your Name: _____Date of Birth: _____/____/_____

Age:_____Gender: M F Social Security Number: _____/_____/_____

Address:

_____

Street City State Zip

Home Phone: (_____)_____ Work:_(_____)_____

Cell:_(_____)_____ Cell 2:_(_____)_____

Marital Status: Single Married Cohabitating Separated Divorced Widowed

Spouse's/Partner's name:_____

Names & ages of children:_____

Employment: _____ Full-Time _____Part-Time Occupation:_____

Name of Employer:_____

Student Status: _____Full-Time Student _____Part-Time Student

Name of school (when applicable):_____

IN CASE OF EMERGENCY

Both legal and professional ethical standards mandate that I take steps to ensure the safety of those with whom I am working. If, during the course of therapy, I become concerned that you are in danger of hurting yourself or others, I am required by law to take steps to ensure safety.

Please provide the following information for an emergency contact:

Name:_____Relationship:_____

Phone Number:(_____)_____

CLIENT HISTORY

1. Have you ever received psychological, psychiatric, or substance abuse treatment before?
Yes No

If yes, please indicate:

When? From Whom? For what?

With what results(what was helpful and what wasn't)?

_____

2. Are you currently or have you ever been prescribed medications for psychiatric or emotional problems? Yes No

If yes, please list:

Current Medications

Names & Dosages: _____

Reason for taking:_____

Person prescribing:_____

Past Medications

Names:_____

Reason for Taking & Reason for Discontinuing:_____

3. Do you have a family history of mental illness or substance abuse? If so, please explain.

_____

4. Major Medical Illnesses, Hospitalizations or Surgeries? If so, please list

_____

5. History of Abuse (sexual or physical) or Domestic Violence? Yes No

PRESENTING CONCERNS

Please briefly explain the reason for seeking therapy:

_____

_____

GOALS

Please identify 3 things that you hope will change as a result of counseling:

1.

2.

3.

Please add any additional information that it would be helpful for me to know in working with you at this time: