Anne Huebner & Associates
Phone: 262-786-9184 262-786-4665
17100 W. North Ave., Ste. 100 Brookfield, WI 53005
Fax: 262-786-1906

ADULT PSYCHOLOGICAL INTAKE EVALUATION

To the Patient: Your responses to the following questions will help your psychologist better understand you and your situation. This will facilitate the best possible treatment. Please answer all questions as completely as possible.

Name:____D.O.B._____/_____/_____Age:______Sex: ____ F ____ M

Address: ____

Home Phone: ______________________Work Phone: _________________________Cell Phone: _________________________

Who referred you/how did you find us? ____

If you feel your psychologist should be aware of any special treatment consideration due to gender, age, disability, sexual orientation or cultural, religious, national, racial or ethnic identity, please explain here:

____

PRESENTING PROBLEM

Check here if you are experiencing any of the following problems:

___ Pain ___ Drug Abuse ___ Eating/Appetite ___ Marital/Relationship
___ Depression ___ Alcohol Abuse ___ Ill Health ___ Family
___ Unstable Mood ___ Stress Management ___ Sexual ___ Employment
___ Suicidal Thoughts ___ Anxiety/Worry ___ Financial ___ Legal
___ Other ____

When did the problem(s) begin? ____

How has it changed over time? ____

____

PSYCHOLOGICAL HISTORY

Have you ever taken medication for anxiety for anxiety, depression, sleep, or other emotional conditions: ____Y _____N

If YES, what and when: ____

____

Have you ever been in counseling or psychotherapy before? _____Y _____N

If YES, when, and where: ____

____

Have you had any past hospitalizations for emotional problems? _____Y _____N

If YES, when, and where: ____

____

Have you ever intentionally hurt yourself or made a suicide attempt? _____Y _____N

If YES, please explain how and when: ____

____

MEDICAL HISTORY

Check if you are currently experiencing or have ever experienced the following medical issues:

__Chronic Pain
__Heart (trouble, disease, surgery)
__Chest pain or angina pectoris
__Abnormal blood pressure
__ Fainting Spells
__ Epilepsy (Seizure Disorder)
__ Neurological disorders
__ Memory Loss
__ Stroke
__ Arthritis/Rheumatism
__ Head Injury
__ Anemia
__ Thyroid problem
__ Kidney or bladder problems
__ Liver Disease
__ Hepatitis- type A B C
__ Jaundice/rashes/sores
__ Frequent or severe headaches
__ Hemophilia blood disease
__ Cancer/Tumors
__ Emphysema
__ Pregnancies not carried to term
__ Allergies
__ Sinus problems
__ Weight change
__ Eating problems
__ Ulcers/Abdominal pain
__ Venereal disease
__ HIV positive/AIDS/ARC
__ Broken Bones
__ Hearing problems
__ Vision problems
__ Other ________________

If you checked any of the above medical items, please explain: ____

____

____

Do you have any allergies or reactions to medications? ___Y ___N

If YES, what medications: ___________________________

Are you taking any prescribed medications? ___Y___N

Who is your primary care physician? ____________________________

Name of Medication	Dose and Frequency	Reason for Medication	Physician

Please indicate any homeopathic or alternative forms of medicine you are currently using: _____________________________

____

Do you smoke or chew tobacco? ____Y____N If so, how much per day or week? _________________________________

Do you drink? ____Y ____N if so, what do you drink and how often? ____

____

FAMILY HISTORY

Please list Parents, Siblings, Spouse, Children and Significant Relatives/Others:

Name (First, Last)	Relationship	Age	School/Occupation	City of Residence

Who raised you?

___Both Parents ___Mother alone ___Mother w/significant other ___ Father alone __Father w/ significant other ___Other

Current Relationship Status:

___Single ___Long-term relationship ___Married ___Re-Married ___Divorced ___Separated ___Widowed

Who currently lives in your household? ____

____

Are you having problems with your children? ___Y ___N

If YES, please explain: ____

____

Have you ever experienced any emotional, verbal, physical, or sexual abuse? ____Y ____N

If YES, please explain: ____

____

Are you concerned about alcohol or drug use of you or someone in your family? ____Y ____N

If YES, please explain: ____

____

Did you grow up in a home in which a parent abused alcohol or drugs? ____Y ____N

If YES, please explain: ____

____

How would you describe your parents' marital relationship? ____

____

Please indicate if any family members have had the following and specify that person's relationship to you.

☐	Cancer	______________	☐	Alcohol abuse	______________
☐	Diabetes	______________	☐	Drug abuse	______________
☐	Epilepsy	______________	☐	Behavior disorder	______________
☐	Migraine headaches	______________	☐	Emotional problems	______________
☐	Physical handicap	______________	☐	Mental illness	______________
☐	Tuberculosis	______________	☐	Mental retardation	______________
☐	Huntington's chorea	______________	☐	Nervousness	______________
☐	Muscular dystrophy	______________	☐	Reading problems	______________
☐	Sickle cell anemia	______________	☐	Learning disability	______________
☐	Tay-sachs disease	______________	☐	Speech problem	______________
☐	Tourette's syndrome	______________	☐	Language problem	______________
☐	Cerebral palsy	______________	☐	Severe head injury	______________
☐	Birth defect	______________	☐	Other	______________

SOCIAL HISTORY

How do you relate to others? Check all that apply:

___ I seem to focus heavily on my interests ___ I am bothered by sounds, textures, smells that other people are not

___ Have many close friends ___ Have several close friends ___ Have few close friends

___ Have no close friends ___ Make friends easily ___ Am a leader

___ Am a follower ___ Fight with others ___ Prefer to be alone

___ Interact well with family members ___ Difficulty with siblings ___ Prefers younger friends

___ Am teased by others ___ Feel rejected by peer group ___ Feel lonely often

___ Have friends who get in trouble ___ Want friends, but don't know how to make or keep them

___ I have difficulty understanding jokes ___ I have difficulty understanding people's feelings

___ I stick to the same routine every day ___ I find change very stressful

If you've had trouble getting along with others, how long has this gone on? ____

____

EDUCATIONAL AND VOCATIONAL HISTORY

Highest grade completed? ___ GED completed? __Y __N How did you do academically in school? ______________________

Were you in any special education programming? __Y __N When/for how long? _____________________________________

How was your conduct throughout school? ____

If attended college, what is your degree and /or status? ____

Name of college: ____

Are you currently employed? ___ Y ___ N If NO, please explain: ____

Please provide a brief overview of your work history starting with you *most recent* job:

JOB TILTLE	EMPLOYER	LENGTH OF EMPLOYMENT

Have you ever been terminated from a job? ___Y ___N

If YES, please explain: ____

____

Do you have any language or reading difficulties? ___Y ___N

If YES, please explain: ____

____

MILITARY HISTORY

Did you ever serve in the military? ___Y ___N Branch of military? ____

Date/Type of Discharge: ____ Do you have combat history? ____Y ____ N

LEGAL HISTORY

Do you have a legal history consisting of past or current: (If YES to any of these, please explain)

Lawsuits ___ Y ___ N ____

Restraining Order ___ Y ___ N ____

Divorce/Custody ___ Y ___ N ____

Arrests ___ Y ___ N ____

Incarceration ___ Y ___ N ____

Probation ___ Y ___ N ____

CULTURAL/RELIGIOUS/SPIRITUAL HISTORY

What is your ethnic or cultural heritage? ____

In what religious tradition did you grow up? ________________________Current religion? _________________________

How important do you consider your ethnicity or religious beliefs/traditions in your life? ___________________________

____

GOALS

What goals would you like to accomplish in treatment?

1) ____

____

2) ____

____

3) ____

____

4) ____

____

5) ____

____

Patient Signature: ____ Date: ________________

Psychologist/Therapist Signature: ____ Date: __________

ADULT SYMPTOM CHECKLIST

Please read each symptom/behavior listed and indicate how often you have experienced it (frequency), and how long you have experienced it (duration).

Symptoms	Rarely	3-4 times month	3-6 times week	Daily	How Long
1. Anxious, tense mood, difficulty controlling worry	0	1	2	3	
2. Panic attacks (intense and sudden fear)	0	1	2	3	
3. Anxiety and/or avoidance in social situations	0	1	2	3	
4. Specific intense fears (e.g. driving, needles, etc.) *Specify:*	0	1	2	3	
5. Obsessions and/or compulsions (excessive concern with cleanliness, orderliness, checking things, etc.).	0	1	2	3	
6. Having urges to break or smash things	0	1	2	3	
7. Difficulty concentrating and focusing on tasks	0	1	2	3	
8. Fatigue, feeling tired even with good sleep	0	1	2	3	
9. Feeling worthless, low self-esteem	0	1	2	3	
10. Decreased interest in previously enjoyed activities	0	1	2	3	
11. Feeling hopeless, things will never change	0	1	2	3	
12. Thoughts of suicide or death	0	1	2	3	
13. Seriously contemplating/planning suicide	0	1	2	3	
14. Sleep problems-too much or too little	0	1	2	3	
15. Decreased interest in sex	0	1	2	3	
16. Preoccupation with sexual thoughts/activities	0	1	2	3	
17. Appetite or weight markedly up or down	0	1	2	3	
18. Episodes of binge eating (with or without vomiting)	0	1	2	3	
19. Excessive worry about weight/body image	0	1	2	3	
20. Irritable mood, snapping at others, easily angered	0	1	2	3	
21. Episodes of rage, really “losing” it	0	1	2	3	
22. Unexplained “up” mood, restless, lots of energy	0	1	2	3	
23. Impulsive behavior that you wouldn’t :normally” do	0	1	2	3	
24. Racing thoughts that you cannot control	0	1	2	3	
25. Seeing/hearing things others tell you are not real	0	1	2	3	
26. Feeling nothing or “numb” emotionally	0	1	2	3	
27. Recurrent, intrusive thoughts or images	0	1	2	3	
28. Easily startled, overly “watchful”	0	1	2	3	
29. Feeling you are watched or talked about by others	0	1	2	3	
30. Difficulty trusting others and feeling safe	0	1	2	3	
31. Persistent fears about health problems despite doctors finding nothing wrong	0	1	2	3	
32. Occupational concerns: job dissatisfaction, problems with employer or co-workers	0	1	2	3	
33. Parenting concerns, difficulty managing children	0	1	2	3	
34. Relationship problems with spouse or other(s)	0	1	2	3	
35. Use of caffeine (coffee, cola, tea, Mt. Dew, etc.)	0	1	2	3	
36. Smoking cigarettes	0	1	2	3	
37. Drinking alcohol (beer, wine, liquor)	0	1	2	3	
38. Use of prescription drugs in non-prescribed ways	0	1	2	3	
39. Use of marijuana, cocaine, or other street drugs	0	1	2	3	