Denton Psychological Services, PLLC
920 North Locust Street
Denton, TX 76201
(940) 383-2211

Intake Form

Date: ____________________

Name:
____
Last First Middle

Date of Birth: ________________ Age:_______ Gender: _______

Race/ethnicity:_______________

Address:
____
Number & Street City State Zip

Phone: (Home) __________________ Can a message be left? __ Yes __ No
(Work) ___________________Can a message be left? __ Yes __ No

If using insurance, please complete the following regarding the primary policy holder.

Name:
____
Last First Middle

Date of Birth: ________________ Age:_______ Gender: _______

Race/ethnicity:_______________

Address:
____
Number & Street City State Zip

Phone: (Home) __________________ Can a message be left? __ Yes __ No
(Work) ___________________Can a message be left? __ Yes __ No

Employer:_______________

Have you previously been a client of Denton Psychological Services? ______ Yes ______ No

How did you learn about Denton Psychological Services? **Newspaper Yellow Pages School Friend**

Other:_______________________________

PEOPLE CURRENTLY IN HOUSEHOLD INCLUDING YOURSEL F

Name	Relationship to Client	Age	Gender	Educational Level	Occupation
1.	self				
2.					
3.					
4.					

Continue on back if necessary.

Any children not living in household?_____________________________________

Gross Family Income (before taxes)$ __________ Number of Dependents_____

Current Concerns

Please describe the concerns, problems, or issues that have motivated you to seek professional services at this time. Indicate which are most important or need most immediate attention:

____

____

____

Current Life Circumstances

Is there anything that has recently happened or is about to happen that represents a major change in your life?

____

____

Is there anything else that your clinician should know about you or your current life circumstances?

____

____

Check any of the following that accurately describe you or your current life circumstances:

_______ overwhelmed
_______ unhealthy eating
_______ excessive caffeine intake
_______ problems at work
_______ misunderstood
_______ low self-esteem
_______ excessive drug use
_______ financial difficulties
_______ health problems
_______ confused
_______ feeling empty
_______ sleep difficulties
_______ excessive alcohol use
_______ inadequate exercise
_______ lonely
_______ persecuted or abused
_______ hopeless
_______ inadequate recreation
_______ spiritual concerns
_______ financial problems
_______ problems with temper
_______ victim of violence
_______ recent traumatic event (what kind?)___________________________

Who are the most important people in your everyday life? (Give first names and their relationship to you):

____

If you are married or involved in an intimate relationship, which of the following terms best describe your relationship? (Check all that apply):

______ happy
______ distant
______ sexually satisfying
______ safe
______ predictable
______ unstable
______ partner supportive of you
______ you supportive of partner
______ trusting
_______ balanced
_______ intolerable
_______ tense
_______ disappointing
_______ partner too dependent on you
_______ you too dependent on partner
_______ affectionate
_______ secure

How long have you been in this relationship?______________

Would your partner be willing to participate in therapy with you?____________

Check any of the following that are sources of conflict or concern in your relationship:

_______ parenting style
_______ politics
_______ communication
_______ finances
_______ mutual interests
_______ parenting responsibilities
_______ religion
_______ lack of mutual caring
_______ sexuality
_______ sharing resources

_______ work loads
_______ sharing housework
_______ your problems
_______ partner's alcohol or drug use
_______ your alcohol or drug use
_______ partner's problems

Marital Information

Current Marital Status: __ Single (never married) __ Married __ Separated

__ Divorced __ Living with committed Partner __ Widowed

Name of Spouse/Significant Other: ______________________________________

Length of Marriage/Relationship: ____

Previous Marriages/Relationships and Durations:

1. __________________________ 3. __________________________

2. __________________________ 4. _________________________

Family of Origin History

Where were you born? (city/town, state) _____________________________________

Where did you live growing up? Please list everywhere you lived for more than five years:
____

How many different places did you live for more than a year up to age 18? ____ places

Raised by: __ Mother __ Father __ Step-Mother __ Step-Father

__ Other: (Who?)____

Listed below are terms describing how your parents may have related to you while you were growing up. Place an "M" for Mother, or "SM" for Stepmother, an "F" for father, "SF" for Stepfather, or "O" for any other primary caregiver next to the terms that best describe their relationship with you as a child.

_____ warm
_____ angry
_____ physically abusive
_____ inconsistent
_____ cruel
_____ sexually intrusive
_____ worried
_____ depressed
_____ loving
_____ unhappy
_____ patient
_____ demanding
_____ understanding
_____ gentle
_____ uninterested
_____ encouraging
_____ preoccupied
_____ cold
_____ trusting
_____ protective

_____ impatient _____ proud of you

Current relationship with parent figures:

Mother: __ Excellent __ Good __ Fair __ Poor __ No Contact
__ Parent Deceased
Father: __ Excellent __ Good __ Fair __ Poor __ No Contact
__ Parent Deceased
Other: __ Excellent __ Good __ Fair __ Poor __ No Contact
__ Parent Deceased

Names and Ages of Siblings – How would you rate your current relationship? (***please check*** good/fair/poor/no contact)

List Name	**List Age**	***Good***	***Fair***	***Poor***	***No Contact***

Was family violence or threat of violence a problem in your family while you were growing up?

____ No ____ Yes

If yes, who was the violent person/people? ______________________________

Were you physically hurt by this person yourself? ____ No ____ Yes

Any history of neglect and/or physical, verbal, emotional, spiritual, or sexual abuse? Please describe briefly.

____

____

Have you ever acted aggressively or violently toward any other person?

____ No ____ Yes

If yes, please describe.
____

____

Have you threatened to do so? ____ No ____ Yes

If yes, please describe.

____

____

Have you ever been physically violent toward another person (outside of sports) since you turned 18? ____ No ____ Yes

Has any other family member been violent with a family member other than you?

____ No ____ Yes

If so, please describe:

____

____

Did you or your family experience any of the following while you were growing up? (***Check*** all that apply to you and put ***F*** for all that apply to family members)

_____ legal problems
_____ divorce
_____ separation
_____ major illness/accident (self)
_____ alcohol/drug problem (parent)
_____ alcohol/drug problem (others)
_____ financial problems
_____ marital conflict
_____ major illness/accident (parent)
_____ major illness/accident (others)
_____ frequent moves
_____ immigration

Is there anything else important for your therapist to know about your family? :

____

Employment History

Are you currently employed? ___ Yes ___ No

If Yes, Where? _________________________________ How Long? ________

Work Performance: ___ Excellent ___ Good ___ Fair ___ Poor

Job Satisfaction: ___ Excellent ___ Good ___ Fair ___ Poor

Previous Employment: ____

Have you ever been fired? ___ Yes ___ No

Any additional employment information:___________________________________

Education History

Any repeated grades? ___ No ___ Yes: _____________________________________

Any skipped grades? ___ No ___ Yes: _____________________________________

Any special classes? ___ No ___ Yes: _____________________________________

Any suspensions? ___ No ___ Yes: _____________________________________

High School Diploma? ___ No ___ Yes:

GED? ___ No ___ Yes:

Highest grade completed:____

Education/training beyond high school: ______________________________________
Any additional education information: _______________________________________

Medical History

Self-Assessment of Health: ___ Excellent ___ Good ___ Fair ___ Poor

Name of Doctor and city located: ____

Any Serious Illness or Hospitalizations? ___ Yes ___ No

If yes, please explain: ____

Any head injuries? ___ Yes ___ No

If yes, please explain: ____

____

1. Was it a closed head injury? ___ Yes ___ No
2. Was it an open head injury? ___ Yes ___ No
3. Were you hospitalized? ___ Yes ___ No
4. Did you receive follow-up care? ___ Yes ___ No
5. Were you unconscious? ___ Yes ___ No
6. Did you experience memory loss? ___ Yes ___ No
7. Did you experience any further complications? ___ Yes ___ No

If yes, please describe complications: ____________________________

____

Sleep difficulties? ___ No ___ Yes

If yes, please describe difficulties: _______________________________

____

Any allergies? ___ No ___ Yes:_________________________

Any current medications? ___ No ___ Yes:_________________________

If so, please list names, dosages, and purposes.

____

____

____

____

Any additional medical information that may be important that was not asked about:

____

Mental Health History

Have you ever received counseling/therapy before? ___ Yes ___ No

If yes, for what problem? : ____

If Yes, Provider or agency name: ____________________________________

Psychiatric Hospitalizations? ___ Yes ___ No

For what problem? : ____

Past Suicidal Ideation? ___ Yes ___ No
Past Suicidal Attempt? ___ Yes ___ No
Past Homicidal Ideation? ___ Yes ___ No
Current Suicidal Ideation? ___ Yes ___ No
Current Homicidal Ideation? ___ Yes ___ No

Is any member of your family currently seeing a mental health professional? ____ If so, please specify which relative(s) and the nature of their problem(s):

____

____

Substance Abuse History

Have you ever had problems with substance abuse (alcohol or drugs)? That is, you were drinking or using to the point that it created problems for you or anyone else?

___ Yes ___ No

Check any that apply:

___ Alcohol
___ Tobacco
___ Caffeine
___ Marijuana
___ Cocaine
___ Amphetamines
___ Other: _________________

Any Additional Substance Abuse Information:_________________________________

____

Legal History

Any prior arrests or incarcerations? ___ Yes ___ No

For what offense? : ____

Any pending legal issues? ___ Yes ___ No

Please describe: ____

Any additional legal history information: _____________________________________

____

Military Service History

Any military service? ___ Yes ___ No Which branch? : ____________

Dates of service: _______________

Any combat-related service? : ___ Yes ___ No

If yes, please describe: ____

____

Type of discharge? ______________

Culture/Ethnicity

How do you identify yourself racially/ethnically? (Please check all that apply.)

___ African American/ Black
___ American Indian/ Alaskan Native
___ Anglo/ European American/ White
___ Asian/ Pacific Islander
___ Hispanic/ Latino/a
___ Jewish
___ Middle Eastern or South Asian
___ Native African
___ Central or South American
___ Other (please list): _________________

Spirituality

What role does spirituality play in your life? __

How do you express your spirituality? __

Do you claim a specific religion? __

If so, please describe. __

How often do you go to religious services? __________________________________

Is your religion or your expression of spirituality similar to what was practiced or expressed in your family of origin? _
__

How long have you been practicing this religion or expressing your spirituality in this manner? ____

Form completed by: ____

Relationship to client: ______________
____

Thank you for completing this form. We appreciate your cooperation and we will do our best to provide you with the professional services most appropriate for you. If you have any questions, do not hesitate to share them with your clinician. If, at any time, you have additional questions or concerns regarding the services you are receiving, we encourage you to call Denton Psychological Services (940)383-2211.