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Older Adult Intake Form

NAME_____ Date of Birth _____

ADDRESS_____

_____

_____

Home Phone: (___ _)_____ May we leave a msg? YES NO

Cell/Other phone: (_____)_____ May we leave a msg? YES NO

Emergency Contact: NAME _____Phone _____

Please circle: Never married partnered married

separated divorced widowed

If married, how many marriages have you had? _____

List the people currently living in your house_____

_____

_____

Name Age Relationship to You Occupation

Statement of Confidentiality

As a psychologist, I seek to provide the quality of services required by the standards of professional psychologists. In keeping with those standards, strict confidentiality of all records of contact is maintained. It is policy not to release personally identifiable information concerning the use of services without prior permission of the person receiving the services. Legally and ethically, confidentiality cannot be maintained when: (1) there is a clear and present danger than someone's life is at risk; (2) in the apparent abuse of a minor; and (3)subpoenaed in a criminal (not civil) judicial preceding. We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials. By law we cannot reveal when we have disclosed such information to the government. If you are concerned about or have questions regarding confidentiality, please discuss them with me. I have read the above statement.

Your signature below indicates that you have read the HIPAA Agreement and agree to its terms and also serves as an acknowledgement of your familiarity with the HIPAA Notice Form.

_____ _____

Client Signature Date

Who Referred You?_____

What was the reason for the referral? _____

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Bold print indicates topics required by NCQA, Medicare, or other insurers. If a family member or other person gave this information, explain the reason why they had to do so. Older adults vary considerably in their ability to complete such questionnaires. Use discretion on whether to have the older adult complete this form themselves.

Briefly describe your goals for therapy: _____

_____

_____

How long have you had this problem? Have any recent events made this problem worse?

_____

_____

Mental Health Background

List any psychotropic medications (medications for your nerves) that you are taking.

Medication Dose/Frequency When Started For What Symptom(s)?

List any previous mental health or substance abuse treatment (include any inpatient or hospital treatment for a mental health or substance abuse disorder) that you have had.

Date of Treatment (approximate)

Name of Treatment Provider or Agency

What Was Your Problem at the Time?

Were Your Treatment Goals Met?

Was anything in your previous treatment particularly helpful? Not helpful?_____

_____

At this time do you ever have thoughts of harming yourself? YES _____ NO _____

Have you ever attempted suicide? YES _____ NO _____

At this time do you ever have thoughts of harming others? YES _____ NO _____

Social History

Education (please circle)

Did Not Finish High School High School Some College

College Graduate or Professional School

Occupation_____

Current (or Past) Employer (or School)_____

How long have you worked there (or did you work there)?_____

Describe your religious or spiritual orientation? _____

If you have a religion, how often do you attend religious services? (Circle one)

At least weekly monthly several times a year once a year or less

Which of the following statements best describe you (check all that apply)

_____ I have a lot of friends with whom I can confide in or count on _____ I have many close family members with whom I can confide in or count on _____ I have a few close friends with whom I can confide in or count on _____ I have a few close family members with whom I can confide in or count on _____ I have a lot of friends, but I can't confide in them or count on them _____ I have few friends and none whom I can confide in or count on

Would you say that you are lonely?

_____ frequently _____ occasionally _____ sometimes _____ rarely

Does your family have a history of mental illness or substance abuse? If so, please explain the nature of the problem, treatment they received and indicate if any particular medication was helpful.

_____

_____

_____

_____

Legal History

Legal Event

If Yes, please give a brief description

Have you ever been arrested?

YES NO

_____

_____

Have you ever been arrested for a DUI (Drinking under the influence?)

YES NO

_____

_____

Have you ever been in prison?

YES NO

_____

_____

Are you currently involved in any litigation?

YES NO

_____

_____

Medical Information

Name of primary care physician or provider _____

Do I have your permission to send basic information (presenting problem, summary of treatment, relevant health information, etc.) to your primary care provider?

YES _____ NO _____

If yes, you will need to sign a specific "authorization" or "release of information form" in order for me to contact your primary care provider.

How would you describe your physical health?
___ excellent ___ good ___ average ___ poor ___ very poor

List any medical conditions that you have.

Medical condition or symptoms Treatment (s)

Please list any prescription medications that you take.

Drug Dose/Frequency When Started For What Symptom(s)?

Please list any non prescription (over-the-counter) medications that you take?
Drug Dose/Frequency When Started For What Symptom(s)?

Do you have any allergies or sensitivities to drugs, foods, or other substances?

YES _____ NO _____

If yes, please indicate the substances that you are allergic to or have sensitivities to:

_____

_____

Do you smoke or use other tobacco products? YES _____ NO _____

If yes, please indicate what you smoke (or chew) and how much you smoke or chew in an average day.

_____

Do you drink alcohol? YES _____ NO _____
If yes, please indicate what you drink and how much you drink in an average day.

_____

_____

Do you use recreational drugs such as marijuana, cocaine, or other drugs?

YES _____ NO _____

If yes, please indicate what you use how much you use in an average week.

_____

_____

Do you take any over the counter medications more often than is recommended?

YES _____ NO _____

If yes, please indicate what you use how much you use in an average week.

_____

_____

Describe your strengths or weaknesses

_____

_____

Is there any other information that would be useful to know about you?

_____

_____