



Grelling Psychology Associates

sensitive, professional care for individuals and families

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www.drgrelling.com

ADULT INTAKE FORM

Please print this form and answer the following questions. Bring this with you to our initial session and we will be able to discuss your responses further. This will help me get to know you and provide the best possible treatment. The information you provide is protected as confidential.

Name: _____

Address: _____

Email: _____

Best phone number to reach you: (____) _____

Is it okay to leave a message at this number? _____

Alternate phone number: (____) _____

Name of emergency contact (optional): _____

Phone number of emergency contact (optional): (____) _____

Birthdate: _____

Age: _____

Current marital status:

Single Separated Committed Relationship

Married Widowed Other

Divorced Dating

Do you have children? _____ If so, what are their ages? _____

If you do not live alone, please list who you live with: _____

Mailing Address: 21C Orinda Way #141, Orinda, CA 94563

Office Address: 61 Avenida de Orinda #100, Orinda, CA 94563

Are you currently employed? _____

If yes, what is your current employment situation? _____

If no, what was your most recent work situation? _____

How did you learn about my psychology practice? _____

What is your reason(s) for seeking therapy at this time? _____

Are you currently feeling sad, depressed or irritable more days than not? _____

Are you grieving the loss of someone(s)? _____

Are you currently troubled by anxiety, panic attacks, or phobia(s)? _____

Do you have chronic pain? _____

Please list any medical condition(s) for which you are being treated: _____

Do you have any problems with your sleep, appetite, energy, concentration, motivation?

_____ (Please circle any/all that apply)

In the past month, have you had any thoughts of harming yourself or thoughts of suicide?

Have you ever attempted suicide or intentionally injured yourself? _____

In the past month, have you had any thoughts of harming anyone else? _____

Do you check things too much (e.g. locks, stove) or do calculations repeatedly? _____

Do you have periods of time with excessive energy, little sleep, and yet don't feel tired?

Do you ever hear voices that other people don't hear? _____

Have you ever had a problem with alcohol or drugs? _____

Have you ever had any problems with the law? _____

Does anyone in your family have a history of mental health problems (including anxiety, depression, bipolar disorder, schizophrenia, suicide, alcohol/drug problems)? _____

In your current relationship(s), has there been any hitting, threatening to harm, or hurting in any way? _____

Have you ever been physically, sexually or emotionally abused? _____

Have you ever been in therapy before? If so, when? _____

Have you ever been hospitalized for mental health reasons? If so, when? _____

Have you ever been prescribed any psychiatric medications? If so, please list.

Please list any medications that you are currently taking: _____

Do you exercise regularly? _____

How much alcohol do you drink in an average week? _____

Do you use marijuana or other drugs? _____

How many caffeinated products do you consume daily? _____

Who can you count on for social support? _____

Do you consider yourself spiritual or religious? _____

What do you consider to be your personal strength(s)? _____

What would you like to accomplish in therapy? _____
