Kathryn Kimball, Ph.D.
Evidence-Based Therapy Services

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PSYCHOSOCIAL INTAKE FORM

SECTION 1: IDENTIFYING INFORMATION

Name: _____ Date of Birth: _____ Age Today: _____

Home Address: _____

Email Address: _____ Best Phone # to reach you: _____

SECTION 2: EMERGENCY INFORMATION

If some kind of emergency arises and we cannot reach you directly, whom should we call?

Name: _____ Relationship: _____

Address: _____ Phone: _____

SECTION 3: MEDICAL & MENTAL HEALTH INFORMATION

Primary Care Physician

Name: _____ Phone: _____

Date of Last Visit: _____ Current Health Problems: Y / N *(circle one)*

If yes, please describe:

_____

_____

Psychiatric Care

Are you ***currently*** seeing a psychiatrist?: Y / N *(circle one)*

If yes, name: _____ Phone _____

Current Psychiatric Diagnosis if known:_____

Have you ever been hospitalized for psychiatric problems: Y / N *(circle one)*

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Psychologists/Other Therapists.

Are you ***currently*** seeing another therapist: Y / N *(circle one)*

Name of ***current and previous*** therapists and dates of service *(use reverse if necessary)*:

Name(s)	**Dates**
_____	From_____ To_____
_____	From_____ To_____

Section 4: Family Information

Any family history of mental health or substance abuse issues (including extended family)? Y / N *(circle one)*

If yes, please describe: _____

_____

_____

Section 5: Occupational Information

Current Employer: _____ Circle if: Unemployed / Student

Address: _____ Phone: _____

Length of time at current employment: _____

Section 6: Social Functioning

Please describe your strengths and resources in each of the following areas:

Interpersonal: _____

Creative: _____

Academic: _____

Athletic: _____

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Please describe your friendships, and note any concerns: _____

_____

_____

Have you experienced changes, undo stress, or trauma in the past year? Y / N *(circle one)*

If yes, please describe: _____

_____

_____

Are there any relevant cultural factors that impact your current functioning or treatment (i.e., sexuality, religious affiliation and traditions, acculturation issues, alternative healing practices)?

If yes, please describe: _____

_____

_____

Section 7: Current Presenting Issues

Please briefly describe any reasons for seeking therapy at this time:

_____

_____

_____

What have you tried to help deal with your current problem? Has it been helpful?

_____

_____

What other relevant information (i.e., concerns, recent events, stressors) would you like me to know?

_____

_____

_____

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DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	