Ψ

Psychological Assessment Intake Form

This form has been designed to ask questions about your history and current symptoms and will provide useful information for your psychological assessment and treatment. While it may be time consuming, please do your best to complete it fully. If you feel uncomfortable completing any sections, feel free to leave them blank.

Identifying Information

Full Name: Barbara B. Date of Birth: 2/20/93

Address: ______________________ Phone: ______________

Email Address: ______________________

Gender: F Race: W Relationship Status: Single

Employment Status: Fulltime Employed For how long? 3 months

Are you on disability? no Type of disability: ______________

Who referred you for a psychological assessment? (Please specify name, address, and relationship)

Self

Are you currently involved in any legal proceedings? (If so, please explain)

No

Chief Complaint/Reason for Referral

Please describe your main reason(s) for seeking an assessment:

Feel tired all the time, no energy
no interest in ~~[illegible]~~ socializing or exercise
dislike my job, can't concentrate on work
disillusioned with advertising career
Feel lonely — difficulty meeting people in this town

Please describe how this problem(s) interferes with your daily functioning. In what areas?

no energy, trouble making new friends
Feel sad much of the time, trouble concentrating

History of chief complaint: Please describe how and when this problem(s) began. Be as specific as possible.

about two months ago, when I started disliking my job, missing friends and college life

Chief complaint history (continued):

Educational History (Please complete the following to the best of your ability)

Highest Grade completed: 16 Degree Earned: B.A.

Mother's highest education level: 16 Father's: 16

What grades did you receive in **elementary school**? Good
In what subjects did you do particularly well? Art, English
In what subjects did you have difficulty? math

What grades did you receive in **middle school**? Good
In what subjects did you do particularly well?
In what subjects did you have difficulty?

What grades did you receive in **high school**? A's & B's
In what subjects did you do particularly well? Art
In what subjects did you have difficulty? math, Chemistry

What grades did you receive in **college**? A's & B's
In what subjects did you do particularly well? Design, Community Service
In what subjects did you have difficulty?

Schools you attended	Public/Private	Years

SAT scores: Verbal: ________ Math: ________ Total: ________ or

Critical ________ Math ________ Writing ________ Total ________

Did you have difficulty transitioning to kindergarten or first grade? (If so, please explain)

no

Did you have difficulty learning to read, write, or use grammar? (If so, please explain)

no

Have you ever had difficulty completing homework? (If so, please explain)

no

What did you do to compensate for the difficulty? ________

Have you ever been placed in special education, or received any form of extra assistance? (If so, please explain) no

Have you ever had to repeat a grade? (If so, please explain)

no

Have you been told by parents or teachers that you had behavioral problems? ________

no

Did you get into physical fights? no

Have you ever been suspended or expelled no

Have you had a psychological assessment for a learning disorder, Attention-Deficit Hyperactivity Disorder, or other psychological condition? no

By whom? ______ When? ______

Diagnoses: ______

Note: if you have been evaluated previously, please provide a copy of the report.

Work History

Current occupation: Junior Account Executive Employer: BBDO&M

Other recent employment:
Barista - College

Have you ever had work difficulties or trouble getting along with bosses or co-workers? (If so, please explain) no

How does your chief complaint relate to your work functioning? Difficulty getting up for work, concentrating

Family History

Does anyone in your family have a history of emotional, behavioral, educational, substance, or medical difficulties or disorders?

Relation to you	Type of Disorder

Medical History

Please answer the following questions to the best of your ability:

Were you born prematurely? no

If so, how many weeks early were you born? ______________

Did your mother have any difficulties during the pregnancy or birth? ______________

Did your mother use alcohol, tobacco, or other drugs during pregnancy? (If so, please explain)

no

Did you have any difficulty reaching developmental milestones (learning to walk, talk, toilette train, adjusting to school, etc)? no

Have you ever had a serious injury or illness?

Illness/Injury	Date	Medical Treatment

Current Medical Status

Please provide the contact information for your primary care physician.

Have you had difficulty with vision, hearing, or other senses? (If so, please explain)

no

Do you have any current medical concerns? (If so, please explain)

Fatigue, sleep problems/low energy [illegible]

Are you currently on any medications? (If so, please explain) no

Alcohol and Drug Use

Please check any of the following that you have used:

		Age at first use:	Last used:
✓	Alcohol		
	Amphetamine		
	Cocaine/crack		
	Heroin/morphine/opium		
	Ecstasy/XTC		
	Glue/solvents/inhalants		
	LSD/psychedelics/PCP		
✓	Marijuana		
	Tobacco		
	Other		

Please estimate your average use:

	Days per week	How much each day	Time since last use
Beer	1		
Wine	1		
Hard Alcohol	0		
Marijuana	0		
Tobacco	0		
Other	0		

Have you ever felt that you should cut down on your substance use? no

Has anyone ever criticized your use or suggested you cut down? no

Have you felt guilty about your use? no

Have you done things you've regretted because of substance use? no

Have you noticed a need to use more of a substance to get the desired effect?

no

Psychological History

Have you ever received treatment for a psychological condition? (If so, please describe the reason for treatment, when it occurred, and with whom you were in treatment)

no

Have you ever had difficulty with the following: (If so, please specify when)

Depressed mood, feelings of helplessness or worthlessness, and decreased motivation

Freshman year – homesick

Stress, anxiety, or tension that was beyond what would be expected for a given event

no

Distressing physical sensations such as shortness of breath, racing heart, dizziness, etc

no

Obsessive thoughts or images that you could not ignore

no

Repetitive behaviors or rituals that you felt compelled to complete

no

Distressing memories, flashbacks, or dreams in response to a traumatic event

no

Over the last two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than ½ the days	Nearly everyday
Little interest or pleasure in doing things		✓		
Feeling down, depressed, or hopeless		✓		
Trouble falling or staying asleep, or sleeping too much		✓		
Feeling tired or having little energy		✓		
Poor appetite or overeating	✓			
Feeling bad about yourself – or that you are a failure or have let yourself or your family down			✓	
Trouble concentrating on things such as reading the newspaper or watching television				✓
Moving or speaking so slowly that other people	✓			

could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	✓			
Thoughts that you would be better off dead, or of *hurting yourself*	✓			

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not at all difficult   Somewhat difficult   Very difficult   Extremely difficult

Have you ever seriously thought about, planned, or attempted to hurt yourself or someone else?

no

Has there ever been a period of time when you were not your usual self and…	Yes	No	
You felt so good, or so hyper, that others thought you were not your normal self?		✓	
Your feeling so good or hyper got you into trouble?		✓	
You were so irritable that you shouted at people or started fights/arguments?		✓	
You got much less sleep than usual, and found you didn't really need it?		✓	
Thoughts raced through your head, or you couldn't slow your mind down?		✓	
You were much more talkative or spoke much faster than usual?		✓	
You were much more active or did many more things than usual?		✓	
You had much more energy than usual?		✓	
You were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		✓	
You were much more interested in sex than usual?		✓	
You did things that were unusual for you or that others thought were risky, foolish, or excessive?		✓	
Spending money got you or your family in trouble?		✓	
You were so easily distracted by things around you that you had trouble concentrating or staying on track?		✓	

If you checked yes to more than one of the above, have several of these ever happened during the same period of time? (If so, please mark which ones above) ____________________

How much of a problem did any of these cause you – like being unable to work; having family, money, or legal troubles; getting into arguments or fights?

No problem   Minor problem   Moderate problem   Serious problem

Have any of your blood relatives been diagnosed with bipolar disorder? no

Please answer the questions below using the option on the right that best describes how you have felt and conducted yourself over the past six months.

	Never	Rarely	Sometimes	Often	Very Often
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?			✓		
How often do you have difficulty getting things in order when you have to do a task that requires organization?			✓		
How often do you have problems remembering appointments or obligations?			✓		
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?			✓		
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?		✓			
How often do you feel overly active and compelled to do things, like you were driven by a motor?		✓			
How often do you make careless mistakes when you have to work on a boring or difficult project?			✓		
How often do you have difficulty keeping your attention when you are doing boring or repetitive work?				✓	
How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?			✓		
How often do you misplace or have difficulty finding things at home or at work?		✓			
How often are you distracted by activity or noise around you?		✓			
How often do you leave your seat in meetings or other situations in which you are expected to remain seated?		✓			
How often do you feel restless or fidgety?		✓			
How often do you have difficulty unwinding and relaxing when you have time to yourself?		✓			
How often do you find yourself talking too much when you are in social situations?		✓			
When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish	✓				

them themselves?					
How often do you have difficulty waiting your turn in situations when turn taking is required?		✓			
How often do you interrupt others when they are busy?	✓				

To complete the assessment it may be necessary to contact additional individuals (parents, teachers, spouse) who can provide another perspective about your historical or current functioning. Please provide full contact information for this person(s).

____

____

____

____

____

____

> By signing this, I authorize Cooper Counseling, LLC to contact the individual(s) indicated above for the purposes of completing a psychological assessment.

Name: Barbora B

Signature: ______________________

Date: ______________________