Kelly Brey Love PhD PC
LICENSED PSYCHOLOGIST

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INTAKE INFORMATION-ADULT (AGE 19 AND OLDER)

Date: _____

Demographic Information:

Individual completing this form (name/relationship to patient): _____
Patient's name: _____ Nickname/Preferred name: _____
Date of birth: _____ Age: _____ Gender: _____
Who referred you to Dr. Love/how did you hear about our office? _____
Primary reason you are here today: _____
_____
_____

(congrats- getting here is the first step!) ☺

Family Information:

Marital status: Never Married Married Engaged Separated Divorced Widowed
Place of employment: _____ Occupation: _____

Highest education level: GED HS Diploma Some College College Degree Graduate Degree Other

Do you live with anyone? (parents, children, roommate, etc). YES NO (If yes, please complete below)

Name	Age	Relationship to you
Name	Age	Relationship to you
Name	Age	Relationship to you
Name	Age	Relationship to you

Do you have a support system? (extended family, close friend, etc) YES NO (If yes, please complete below)

Name	How often seen?	Relationship to you
Name	How often seen?	Relationship to you

Medical Information:

Who is your Primary Care Physician (PCP)? _____ Phone: _____
May I share information pertinent to your treatment with your PCP? YES NO
Any recent/relevant hospitalizations, surgeries, or emergency room visits? YES NO
If yes, please briefly describe:
_____
Previous medical diagnoses/conditions: YES NO
If yes, please briefly describe:
_____

Current medical diagnoses/conditions: YES NO
If yes, please briefly describe:

_____

Any sexual/menstrual concerns? YES NO
If yes, please briefly describe:

_____

Mental Health History:

Have you ever received mental health care treatment (psychologist, psychiatrist, counselor, etc)? YES NO

Start/end date	Provider name	Reason for treatment	Diagnosis (if known)	Outcome (None, Poor, Fair, Good, Excellent)

Current psychiatric medications	Dosage	Start date	Reason for taking	Prescriber

Family history of mental health concerns/mental health treatment: YES NO
If yes, please briefly describe diagnosis and relationship to you:

_____

Significant relevant family medical history? YES NO
If yes, please briefly describe diagnosis and relationship to you:

_____

Social Information:

Do you have a history of substance use/abuse (including nicotine)? YES NO DK If yes, please describe:

_____

Family members have a history of substance use/abuse (including nicotine? YES NO DK If yes, please describe:

_____

Do you have a history of abuse or neglect? YES NO DK If yes please describe

_____

Do you have any current or previous legal concerns, or offender issues? YES NO DK If yes please describe:

_____

Family members have any current/previous legal concerns, or offender issues? YES NO DK If yes please describe

_____

Spiritual beliefs/orientation: _____

Cultural/ethnic identification or important beliefs: _____