DEL MUNDO
PSYCHOLOGICAL, APC

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INTAKE FORM

Identification

Name:_____ DOB:_____

Address:_____

Phone Number:_____ Referred by:_____

Please briefly describe your reasons/goals for treatment:_____
_____
_____
_____
_____

Demographics

Age:_____ Gender: _____ Highest level of education:_____

Cultural/racial and/or religious/spiritual background (optional):_____

Hobbies and interests:_____

Marital status: _____ Name of partner: _____Time together: _____

Names and ages of children:_____

People in your current household:_____

Occupation:_____ If student, grade:_____

Mental Health History

Which of the following psychological/psychiatric services have you received prior? Please mark all that apply.
☐ None ☐ Outpatient ☐ Partial hospitalization ☐ Inpatient care ☐ Other 24-hour care

For each of the psychological/psychiatric services indicated above, please list the frequency as well as beginning and end dates of treatment.
_____
_____
_____

Have you recently experienced any of the following?

- ☐ Depression/sadness
- ☐ Fatigue/tiredness
- ☐ Low motivation/energy
- ☐ Social isolation
- ☐ Self-injury
- ☐ Suicidal ideas
- ☐ Inability to enjoy things
- ☐ Mood swings
- ☐ Appetite changes
- ☐ Weight changes
- ☐ Disordered eating
- ☐ Purging behavior
- ☐ Anxiety/nervousness
- ☐ Inability to relax
- ☐ Tense
- ☐ Phobias/fear
- ☐ Excessive worry
- ☐ Perfectionism
- ☐ Panic attacks
- ☐ Obsessions or compulsions
- ☐ Flashbacks
- ☐ Nightmares
- ☐ Hallucinations
- ☐ Odd beliefs
- ☐ Behavioral problems
- ☐ Aggression
- ☐ Anger
- ☐ Criminal activity/incarceration
- ☐ Recurrent conflict with others
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Trouble focusing/concentrating
- ☐ School or work problems
- ☐ Recent trauma or loss
- ☐ Crisis
- ☐ Alcohol or drug use (If yes, please describe:_____)

If you have ever attempted suicide, when did your most recent attempt occur?

_____

_____

Has anyone in your family experienced the following?

☐ Depression ☐ Anxiety ☐ Bipolar disorder ☐ Psychosis ☐ Alcohol or drug use ☐ Suicide
☐ Learning disorder ☐ Developmental delays ☐ Learning disability ☐ ADHD ☐ Criminal behavior

Medical History

Date of last medical evaluation and reason for appointment:_____

_____

Please list any current medical conditions/diagnoses and related treatment:_____

_____

_____

_____

_____

Please note any past medical conditions, accidents, surgeries, procedures, etc.:_____

_____

_____

_____

_____

If you are taking medication, please note medications, doses, and frequencies:_____

_____

_____

Name of prescribing physician:_____ Phone number:_____

Emergency Contact:_____ Phone number:_____

Developmental History

Describe your childhood:_____

Have you ever been exposed to any type of trauma or abuse, including verbal, emotional, physical, or sexual? If yes, please describe:_____

Describe your family of origin (parents, caregivers, and siblings):_____

Describe any past marital relationships or domestic partnerships (name, years together, and nature or relationship):_____

Legal History

Are you currently involved in any current or pending litigation processes including lawsuits, divorce, custody disputes, etc.? If yes, please describe:_____

If you have ever been arrested, please describe:_____

Is there any other information you would like to provide that may be relevant to your treatment?:_____