Compass Psychological Services, LLC
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Intake Questionnaire- Adult

BACKGROUND INFORMATION

Date: _____/_____/_____

Name:_____ Sex: M or F DOB:____/____/____

Address:_____

City: _____ State: _____ Zip:_____

Phone: _____ Cell: _____

Email: _____

Relationship status: (please circle) single married divorced

Spouse's Name:_____

Do you have any children? If yes, name and ages of children:_____
_____
_____

MEDICAL HISTORY

Physician: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone _____

Who referred you for evaluation/consultation: _____

What concerns are you experiencing that made you seek psychological services at this time?
_____

_____
_____

When did these concerns start? _____
_____
_____

What would you like to accomplish during this evaluation or therapy?
_____
_____
_____

Current medical problems, medications and medication allergies:
_____
_____

Please list any hospital admissions or emergency room visits:

_____	_____	_____
Date	Hospital	Reason for Admission
_____	_____	_____
Date	Hospital	Reason for Admission

Please list any medications you are taking on a regular basis:
_____
_____
_____

Has your hearing and vision ever been checked (circle) Yes or No
If yes, where and what were the results?
_____
_____

Educational History

Level of education completed: _____

Did you experience any academic or behavioral difficulties during your school years:
_____
_____
_____

Previous Evaluations

Please list all previous evaluations you have had:

Date	Type of Professional	Results

Is there anybody in the family with any of the following (circle all that apply)

Developmental delay	*Mental Retardation*	*Learning disability*
ADHD	*Autism/PDD*	*Seizure Disorder*
Anxiety	*Depression*	*OCD*
Bipolar Disorder	*Eating Disorder*	*Schizophrenia*
Substance Use	*Attempted/Completed Suicide*	

*Other:*_____