

MID-OHIO PSYCHOLOGICAL SERVICES, INC.
CLIENT SELF-REPORT PSYCHO-SOCIAL INTAKE
(Adult Form)

Client Name _____ Date _____

Gender _____ Date of Birth _____ Age _____

Race/Ethnic _____ County of Residence _____

Social Security Number _____ Phone # _____

Permanent Address _____

Emergency Contact _____ Phone # _____ Relationship _____

Address _____

Case Manager (Name/Agency) _____ Attorney _____

Legal Status/Guardian _____

Who sent you to this agency? _____

FAMILY & SOCIAL INFORMATION

Current Marital Status _____ Length of time _____

Names of Spouses and Date of Previous Marriages _____

Names, ages of your children and name of their other parent _____

Support System _____

Community Interests/Involvement _____

Religious/Spiritual Involvement _____

Legal System Involvement (Present/Past/Juvenile) _____

EDUCATIONAL & OCCUPATIONAL HISTORY

Highest grade completed in school _____ School _____

Were you ever in special classes (explain) _____

Extracurricular Activities _____

Current Occupation/Source of Income _____

Employment History

Date	Employer	Type of Work	How Terminated

Military History:

Branch	Years of Service	Type of Discharge

Other Sources of Income _____

ABUSE HISTORY
(note if Child or Adult)

Have you ever been physically abused (describe) _____

Have you ever been sexually abused (describe) _____

Have you ever been mentally abused (describe) _____

Have you ever been neglected (describe) _____

History of Domestic Violence _____

Have you ever used the following	Please Check	How often do you use?	When did you last use?
Alcohol			
Marijuana (pot, weed, etc.)			
Cocaine (crack, rock, etc.)			
Depressants (Xanax, Ativan, Klonopin, downers)			
Amphetamines (uppers, meth, Ritalin, Adderall)			
Hallucinogens (LSD, acid, "shrooms," salvia)			
Opiates (heroin, morphine, Oxy, pain medication, suboxone)			
Inhalants (huffing, poppers, whip-its, dusters)			
K2, bath salts, spice			
Other Substances			
Tobacco			
Caffeine			

Have you ever had problems with gambling, eating behaviors, sex _____

MENTAL HEALTH HISTORY

Have you ever seen a counselor before (describe) _____

Have you ever been in a psychiatric hospital (describe) _____

Have you ever had hallucinations (describe) _____

Have you ever attempted suicide (describe) _____

Have you ever received treatment for a drug or alcohol problem _____

Why are you seeking counseling at the present time (Please give details) _____
