AGIUS PSYCHOLOGY
Professional Corporation

Intake Form - Adults

Name: **Date of Birth:**

Please tell us why you are seeking services for yourself...:

Have you previously sought services for this issue?:

◯ Yes ◯ No

If Yes, what services have you had for this issue and when?:

Your current symptoms

(check all that apply)

- ☐ Anxiety
- ☐ Appetite Issues
- ☐ Avoidance
- ☐ Crying Spells
- ☐ Depression
- ☐ Excessive Energy
- ☐ Fatigue
- ☐ Hallucinations
- ☐ Impulsivity
- ☐ Irritability
- ☐ Libido Changes
- ☐ Loss of Interest
- ☐ Panic Attacks
- ☐ Sleep Changes

Have you experienced suicidal or homicidal thoughts or attempts in the past three (3) months?: ◯ Yes ◯ No

Are you currently experiencing suicidal or homicidal thoughts?: ◯ Yes ◯ No

PLEASE NOTE: If you have answered yes to either of the above questions you will be contacted by a member of our clinical team.

Your Family History

Please list your family members names, relationship and age...:

How is/was your relationship with your mother?:

How is/was your relationship with your father?:

Who raised you? Where did you grown up?:

Please list any mental health conditions in your family:

Present Situation

Employment Status:

What is your marital status:

What is your sexual orientation?:

Are you sexually active?:

Do you have children? If yes, how is your relationship with your child(ren)?:

Are you a member of a religion/spiritual group?:

Have you ever been arrested? If yes, when and why?:

Your Medical History

Please list all of your current medical conditions and allergies:

Please list all of your current medications:

Have you ever been treated for drug/alcohol abuse? If yes, when?:

Do you smoke cigarettes? If yes, how many per day?:

Do you drink caffeinated beverages? If yes, how many per day?:

Have you ever abused prescription drugs? If yes, which ones?: