Advance Potential

PSYCHOLOGICAL SERVICES

Adult Contact and Background Information

Please complete all forms thoroughly. If you have questions, please ask your APPS provider.

Adult Contact Information

Name: ____ Date: ___________________

Address: ____

City: _________________ State: _____ Zip: ________

Date of Birth: ____________ Gender: M___ F___ Age: ______

Insurance Information

Health Insurance Company:_________________________

Subscriber Name: _______________________ Date of Birth: _______________________

ID number: ___________________________ Group/Policy #: __________________________

Contact Telephone Numbers

Please complete relevant information and indicate the number at which you wish to be contacted first.

PHONE NUMBERS

HOME: ( ) _______________________ Ok to leave messages? Yes ☐ No ☐

WORK: ( ) _______________________ Ok to leave messages? Yes ☐ No ☐

CELL: ( ) _______________________ Ok to leave messages? Yes ☐ No ☐

Your Marital Status

Single
Divorced (____ years)
Living as Married (_____ years)

Married (_____ years)
Separated (_____ years)
Widowed (_____ years)

Are you currently involved in any divorce or child custody proceedings? Yes ☐ No ☐

If yes, please explain:

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Spouse/Partner's Name: ____

If APPS is unable to reach you, may we contact your spouse/partner? Yes ☐ No ☐

If yes, spouse/partner's phone number: **( )** ________________________

Military Service

Have you been/are you currently in the military? (If no, skip remainder of this section)
Yes ☐ No ☐

Branch _______________ Rank ____

Date of Discharge ________ Type of Discharge _________

Were you in combat? Yes ☐ No ☐

Employment Status

Are you employed? Yes ☐ No ☐

Employer Name: ____

Position: __________________________________

Length of time in this position: ____________

Stress level of this position: Low☐ Medium ☐ High ☐

Other jobs you have held:

Emergency Contact Information

Name: ____

Address: ____

Phone: ( ) _______________________ Relationship to you: _____________________

Primary Care Physician & Medical Care

Current Physician: ____

Physician Address: ____

Primary Care Physician Phone #: ( ) __________________ Fax #: ( ) __________________

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Medical: ________________________________

MEDICAL INFORMATION

Date of last physical exam: ______________________

Have you experienced any of the following medical conditions during your lifetime?

Allergies	Asthma	Headaches	Stomach Aches
Chronic Pain	Surgery	Serious Accident	Head Injury
Dizziness/Fainting	Meningitis	Seizures	Vision Problems
High Fevers	Diabetes	Hearing Problems	Miscarriage
Sexually Transmitted Disease	Abortion	Sleep Disorder	Other (please list):

Please list any CURRENT health concerns:

Current prescription medications:

Medication Dosage: _______________ Date First Prescribed: ___________

Prescribed By: ____

Current over-the-counter medications (including vitamins, herbal remedies, etc.):

Please list any allergies and/or adverse reactions to medications:

PREVIOUS MENTAL HEALTH TREATMENT

Yes ☐ No ☐

If yes: Dates of Treatment: From _________ to __________

Provider/Program ____

Outpatient Counseling ______ Medication (mental health) ______

Psychiatric Hospitalization ______ Drug/Alcohol Treatment _________

Self-help/Support Groups _______

SUBSTANCE USE HISTORY

Substance Type _______ Current Use (last 6 months) Yes ☐ No ☐

Past Use: Yes ☐ No ☐

Please complete all that apply:

Substance	Frequency	Amount
Tobacco		
Caffeine		
Alcohol		
Cocaine/ Crack		
Ecstasy		
Heroin		
Inhalants		
Methamphetamines		
Pain Killers		
PCP/ LSD		
Steroids		
Tranquilizers		
Marijuana		

Have you had withdrawal symptoms when trying to stop using any substances?
Yes ☐ No ☐ If yes, please describe:

Have you ever had problems with work, relationships, health, the law, etc. due to your substance use?
Yes ☐ No ☐ If yes, please describe:

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your social support network (check all that apply):

Family ☐ Neighbors ☐ Friends ☐ Students ☐ Co-workers ☐

Support/Self-Help Group ☐ Community Group ☐

Religious/Spiritual Center (which one?): ______________________________

To which cultural or ethnic group do you belong? ___________________

If you are experiencing any difficulties due to cultural or ethnic issues, please describe:

How important are spiritual matters to you?

Not at all ☐ Somewhat ☐ Very Much ☐

Would you like spiritual/religious beliefs to be incorporated into your counseling?

Yes ☐ No ☐

Education

Are you currently attending school? Yes ☐ No ☐

High School Graduate ☐ GED ☐ Year _____________

Associate's Degree Year ___________ Major area of study __________________________

Undergraduate Degree Year ________ Major area of study ________________________

Graduate Degree Year ____________ Major area of study ____________________________

About You

Please describe your strengths, skills, and talents:

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.):

Who referred you to APPS? ____

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