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 #: ( ) _____

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 _____

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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?): _____

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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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