



**GREAT PLAINS PSYCHOLOGICAL SERVICES**  
**4105 S. Carnegie Place, Sioux Falls, SD 57106**  
**(605)323-2345 – phone**  
**605-323-2822 – fax**

*This box to be completed by GPPS Staff*

Appointment Date: \_\_\_\_\_

Evaluator: \_\_\_\_\_

Evaluation Location: \_\_\_\_\_

**FORENSIC EVALUATION  
 INTAKE FORM**

**INDIVIDUAL BEING EVALUATED:**

*Has this individual previously received services from our agency?*     yes     no

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
First MI Last

Address: \_\_\_\_\_  
Street Address City State Zip Code

Home Phone: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

School

Employer: \_\_\_\_\_  
Employer / School Name Occupation

Sex:  M  F Social Security#: \_\_\_\_\_ *Optional:* Race/Ethnic Group:  Black  White

Hispanic  Asian/Pacific Islander

Is this individual a minor?  yes  no

American Indian/Alaskan Native

Other \_\_\_\_\_

*If yes, please complete the following information. If no, please continue to the next section.*

Parent/Legal Guardian Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone(s): \_\_\_\_\_ Work Phone(s): \_\_\_\_\_

Employer Name(s): \_\_\_\_\_

Social Security #( 's ): \_\_\_\_\_

**Others residing in household:**

Name	Relationship to Participant	Age	Birthdate	School/Employer

**Medical Information**

Primary Physician: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Presenting Concern (Optional): \_\_\_\_\_

**Referral Source / Contact Information**

Reason for Evaluation: \_\_\_\_\_

Is this evaluation court ordered?  yes  no

Who is the referring party for this evaluation? \_\_\_\_\_  
Full Name Agency Name

Address Phone Fax#

Is a report required for this evaluation?  yes  no

Who is responsible for payment of this evaluation? \_\_\_\_\_

***Please note that any third party funding source must provide a written authorization confirming financial responsibility.***

**Information about Individual Being Evaluated:**

**EDUCATION:**

Level of Education: \_\_\_\_\_ Type of Grades Received in School: \_\_\_\_\_

Please list any special needs: \_\_\_\_\_

Please list any reading or learning difficulties: \_\_\_\_\_

Will assistance be needed for testing?  yes  no

Type of classes taken in school. (Regular, Advanced, Resource Room, Special Ed.) \_\_\_\_\_

Is there or has there been an IEP at school?  yes  no

If yes, is this information being forwarded to us?  yes  no

Who should we contact to obtain this information? \_\_\_\_\_  
Full Name School/Organization

Address phone # fax#

**Previous Mental Health Services:**

Has this individual received previous mental health services?  yes  no

If so, will this information be forwarded to us?  yes  no

Who should we contact to obtain this information? \_\_\_\_\_  
Full Name Agency Name

Address phone# fax #

**Previous Evaluations:**

Has this individual had a previous evaluation?  yes  no

If so, will this information be forwarded to us?  yes  no

Who should we contact to obtain this information? \_\_\_\_\_  
Full Name Agency Name

Address phone# fax