Intake Questionnaire For New Patients (Adult)

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible, All information that you provide us will be **confidential** as required by state and federal law.

Cell Phone: _____

Home Phone: _____

Home Address: _____

Marital Status

☐ Single ☐ Married ☐ Remarried
☐ Separated ☐ Divorced ☐ Engaged
☐ Widowed ☐ Cohabitating

Partner Information

If applicable, please complete the following:
Partner's Name: _____
Partner's Occupation: _____ Age: _____

Do you have children?

Name	Sex	Age

Who lives in your residence? (Adults and Children)

Name	Relation	Sex	Age

In your own words, describe the current problems as you see them:

_____

_____

_____

_____

_____

How long has this been going on? _____

_____

What made you come in at this time? _____

_____

_____

What do you hope to gain from this evaluation and/or counseling?

_____

_____

_____

_____

If you had difficulties in the past, what have you done to cope? Was it helpful? _____

_____

_____

Symptoms

Please **check** any symptoms or experiences that you have had **in the last month**

☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Difficulty getting out of bed

☐ Not feeling rested in the morning Average hours of sleep per night:_____

☐ Persistent loss of interest in previously enjoyed activities ☐ Avoiding people, places, activities or specific things

☐ Withdrawing from other people ☐ Spending increased time alone ☐ Feeling Numb

☐ Anxiety/Panic attacks ☐ Frequent feelings of guilt ☐ Difficulty leaving your home

☐ Depressed Mood ☐ Rapid mood changes ☐ Outbursts of anger

☐ Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)

☐ Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: _____

☐ Worthlessness ☐ Sadness ☐ Hopelessness ☐ Fear

☐ Helplessness ☐ Feeling or acting like a different person

☐ Changes in eating/appetite ☐ Excessive exercise to avoid weight gain

☐ Eating more ☐ Eating less ☐ Use of laxatives ☐ Binge eating

☐ Voluntary vomiting ☐ Weight gain:_____lbs ☐ Weight loss:_____lbs

Are you trying to lose weight? _____

☐ Decreased energy ☐ Easily started, feeling "jumpy" ☐ Difficulty catching your breath

☐ Increased energy ☐ Tremor ☐ Increase muscle tension ☐ Physical sensations others don't have

☐ Unusual sweating ☐ Racing thoughts ☐ Frequent worry ☐ Intrusive memories ☐ Dizziness

☐ Large gaps in memory ☐ Flashbacks ☐ Nightmares ☐ Difficulty concentrating or thinking

☐ Thoughts about harming or killing yourself ☐ Thoughts about harming or killing someone else

☐ Feeling as if you were outside yourself, detached, observing what you are doing

☐ Unusual visual experiences such as flashes of light, shadows

☐ Feeling that the television or the radio is communicating with you ☐ Hear voices when no one else is present

☐ Feeling puzzled as to what is real and unreal ☐ Difficulty problem solving

☐ Persistent, repetitive, intrusive thoughts, impulses, or images ☐ Dependency on others

☐ Feeling that your thoughts are controlled or placed in your mind ☐ Inappropriate expression of anger

☐ Difficulty or inability to say "no" to others ☐ Sense of lack of control

☐ Manipulation of others to fulfill your own desires ☐ Abusive relationship

☐ Self-mutilation./cutting ☐ Concerns about your sexuality ☐ Ineffective communication

☐ Decreased ability to handle stress ☐ Difficulty meeting role expectations ☐ Difficulty expressing emotions

☐ Fever or chills ☐ Chest pain or pressure ☐ Muscle or joint pain

☐ Change in stools ☐ Rapid heart rate ☐ Change in sexual function

☐ Visual changes ☐ Cough ☐ Burning or tingling sensation

☐ Hearing Loss ☐ Abdominal pain ☐ Nausea or Vomiting

☐ Sore/Scratchy throat ☐ Change in urination ☐ Rash or sores

☐ Headache ☐ Balance problems

Please describe any other symptoms or experiences you have had problems with:

_____

_____

_____

Sexual Orientation:_____

MEDICAL HISTORY

Have you seen a counselor, psychologist, psychiatrist or other mental health professional before? ☐ Yes ☐ No

Name of therapist:_____ Reason:_____ Dates of Treatment:_____

Name of therapist:_____ Reason:_____ Dates of Treatment:_____

Do you have any **Medication Allergies?** ☐ Yes ☐ No *If yes, please list:*

Medication Name	Reaction

Are you currently taking **Psychiatric** medication? ☐ Yes ☐ No *If yes, please list:*

Medication	Dose	How long have you been taking it?	Has it been helpful?

Are you currently taking **Non-Psychiatric** medication? ☐ Yes ☐ No *If yes, please list:*

Medication	Dose	How long have you been taking it?

Were you ever on **Psychiatric** Medication in the past? ☐ Yes ☐ No *If yes, please list:*

Medication	Dose	Start/End Dates	Effect of Medication

Have you ever been **hospitalized** for psychiatric reasons? ☐ Yes ☐ No *If yes, please list:*

Hospital	Dates	Reason

Have you ever attempted suicide? ☐ Yes ☐ No *If yes, please explain:*

____

____

____

____

Are you currently receiving treatment for any medical condition? ☐ Yes ☐ No *If yes, please explain:*

____

____

____

____

List any prior illnesses, operations and/or accidents (from childhood to present):

____

____

____

____

FAMILY HISTORY

Father: Age: ☐ Living ☐ Deceased *If deceased:* Cause of death: ______________

Occupation: ______________ Health: ______________ Father's age at time of death: ________

Frequency of contact: ______________ Are you/Were you close to him?______ Your age at time of death: ________

Mother: Age: ☐ Living ☐ Deceased *If deceased:* Cause of death: ______________

Occupation: ______________ Health: ______________ Mother's age at time of death:________

Frequency of contact: ______________ Are you/Were you close to her? ______ Your age at time of death: ________

Siblings

Name	Sex	Age	Whereabouts	Are you close to him/her?			
					No		Yes
					No		Yes
					No		Yes
					No		Yes

Please place a check mark in the appropriate box if these are or have been present in your relatives

	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
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During your childhood, did you live any significant period of time with anyone other than your natural parents?

☐ Yes ☐ No *If yes, please explain*

Name: _____ Relationship to you: _____

SOCIAL HISTORY

Have you been married before? ☐ Yes ☐ No *If Yes, please describe*

When? _____ How long? _____

When? _____ How long? _____

Highest grade level completed: _____ Degree obtained, if applicable: _____

Did you have any disciplinary problems in school? _____ If yes, please explain, _____

Were you considered hyperactive/ADHD in school? _____

If yes, were/are you on any medication? _____ If yes, what medication? _____

What kinds of grades did you get in school? _____

Have you served in the military? ☐ Yes ☐ No *If yes, please describe:* _____

_____

What type of discharge (separation) did you get? _____

Are you currently employed? ☐ Yes ☐ No *Please list current employment and past employment (most recent first)*

Employer	Type of work	Dates	Reason for leaving

Do you have a religious affiliation? ☐ Yes ☐ No *If yes, please describe:* _____

_____

What kind of social activities do you participate in? _____

_____

Who do you turn to for help with your problems? _____

_____

Have you ever been abused? ☐ Verbally ☐ Emotionally ☐ Physically ☐ Sexually ☐ Neglected

If any checked above, please describe:

_____

_____

_____

_____

Early History

How would you describe your early childhood relationship with your parents?

Were there any major traumas (deaths, accidents, abuse) in your childhood that has affected your life greatly?

Childhood (Birth to Pre-Teen)

Describe any problems (psychological or behavioral) you had as a child:

In general, how would you describe how you felt as a child (check all that apply):

☐ Sad ☐ Happy ☐ Worried ☐ Lonely ☐ Angry ☐ Stimulated

Teenage Years

Describe any problems (psychological or behavioral) you had as a teen:

In general, how would you describe how you felt as a teen (check all that apply):

☐ Sad ☐ Happy ☐ Worried ☐ Lonely ☐ Angry ☐ Stimulated

Did you have many friends?_____ Did you go on many dates? _____

Were you held back in school? _____

Were you ever involved in special education classes in school? _____

If so, what types of services did you receive and for how long? _____

Do you feel you have any difficulties with reading, spelling or arithmetic? _____

Do you have any future plans involving further education? _____

SUBSTANCE ABUSE

Do you drink alcohol? ☐ Yes ☐ No If yes, age of first use: _____

How much do you drink? _____ How often do you drink? _____

Have you ever passed out from drinking? _____ How often? _____

Have you ever blacked out from drinking? _____ How often? _____

Have you ever had the "shakes"? _____ How often? _____

Have you ever felt you should cut down on your drinking/drug use? _____

Have people annoyed you by criticizing your drinking/drug use? _____

Have you ever felt bad or guilty about your drinking/drug use? _____

Have you ever drank/used drugs in the morning to steady your nerves or relieve a hangover?

Do you use tobacco? _____ If yes, how often? _____

Please indicate past and present drug use below:

Drug	Ever Used?	Age at 1st use	Time Since Last Use	Approx use in the last 30 days
Marijuana	☐ ☐			
	☐ ☐			
	☐ ☐			
	☐ ☐			
	☐ ☐			
	☐ ☐			

Legal Issues

Are you currently involved in any of the following legal issues? (Check all that apply)

☐ Custody of children ☐ Legal suit due to injury ☐ Workmen's comp ☐ Divorce ☐ Appeal for financial benefits

Have you ever been in trouble with the law?_____

_____

Are you currently on probation or parole? ☐ Yes ☐ No

Have you ever been on probation or parole? ☐ Yes ☐ No

Personality Assessment

List any faults you think you have?_____

_____

_____

_____

_____

List your personal strengths and good points:_____

_____

_____

_____

_____

Please add anything else you feel might help us understand your problem or help you better:_____

_____

_____

_____

_____

The Holmes-Rahe Scale

Read each of the events listed below, and **check the box** next to any even which has occurred in your life **in the last two (2) years.** There are no right or wrong answers. The aim is to identify which of these events you have experienced lately.

Life Events	Life Crisis Units	

Life Events	Life Crisis Units	