

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.

Date: _____ **Social Security Number:** _____

Name: _____ **Date of Birth:** _____ **Age:** _____

Home Address: _____ **City/State/Zip code:** _____

Home Phone: _____ **Cellular/Alternate Phone:** _____

Marital Status: single married separated divorced
 remarried engaged widowed cohabiting

If applicable, please complete the following:

Partner's Name: _____ **Partner's Age:** _____

Partner's Occupation: _____

IF YOU HAVE CHILDREN PLEASE LIST THEIR NAMES AND AGES:

#	Name	Sex	Age	#	Name	Sex	Age
1				4			
2				5			
3				6			

WHO CURRENTLY LIVES IN YOUR RESIDENCE (adults and children):

#	Name	Relation	Sex	Age	#	Name	Relation	Sex	Age
1					4				
2					5				
3					6				

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**

- | | |
|--|--|
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Difficulty staying asleep |
| <input type="checkbox"/> Difficulty getting out of bed | <input type="checkbox"/> Not feeling rested in the morning |
| Average hours of sleep per night: _____ | |

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- | | |
|--|---|
| <input type="checkbox"/> Persistent loss of interest in previously enjoyed activities | |
| <input type="checkbox"/> Withdrawing from other people | <input type="checkbox"/> Spending increased time alone |
| <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Feeling Numb |
| <input type="checkbox"/> Rapid mood changes | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Frequent feelings of guilt | <input type="checkbox"/> Avoiding people, places, activities or specific things |
| <input type="checkbox"/> Difficulty leaving your home | |
| <input type="checkbox"/> Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: _____ | |
| <input type="checkbox"/> Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands) | |
| <input type="checkbox"/> Outbursts of anger | |

-
- | | |
|--|--|
| <input type="checkbox"/> Worthlessness | <input type="checkbox"/> Hopelessness |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Helplessness |
| <input type="checkbox"/> Fear | <input type="checkbox"/> Feeling or acting like a different person |

-
- | | |
|--|--|
| <input type="checkbox"/> Changes in eating/appetite | |
| <input type="checkbox"/> Eating more | <input type="checkbox"/> Eating less |
| <input type="checkbox"/> Voluntary vomiting | <input type="checkbox"/> Use of laxatives |
| <input type="checkbox"/> Excessive exercise to avoid weight gain | <input type="checkbox"/> Binge eating |
| <input type="checkbox"/> Are you trying to lose weight? _____ | |
| <input type="checkbox"/> Weight gain: _____ lbs | <input type="checkbox"/> Weight loss: _____ lbs. |

-
- | | |
|--|--|
| <input type="checkbox"/> Difficulty catching your breath | <input type="checkbox"/> Increase muscle tension |
| <input type="checkbox"/> Unusual sweating | <input type="checkbox"/> Easily started, feeling "jumpy" |
| <input type="checkbox"/> Increased energy | <input type="checkbox"/> Decreased energy |
| <input type="checkbox"/> Tremor | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Frequent worry | <input type="checkbox"/> Physical sensations others don't have |
| <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Intrusive memories |

- Difficulty concentrating or thinking
- Flashbacks
- Thoughts about harming or killing yourself
- Large gaps in memory
- Nightmares
- Thoughts about harming or killing someone else
- Feeling as if you were outside yourself, detached, observing what you are doing
- Feeling puzzled as to what is real and unreal
- Persistent, repetitive, intrusive thoughts, impulses, or images
- Unusual visual experiences such as flashes of light, shadows
- Hear voices when no one else is present
- Feeling that your thoughts are controlled or placed in your mind
- Feeling that the television or the radio is communicating with you
- Difficulty problem solving
- Dependency on others
- Inappropriate expression of anger
- Difficulty or inability to say "no" to others
- Sense of lack of control
- Abusive relationship
- Concerns about your sexuality
- Difficulty meeting role expectations
- Manipulation of others to fulfill your own desires
- Self-mutilation/cutting
- Ineffective communication
- Decreased ability to handle stress
- Difficulty expression emotions

Sexual Orientation: Heterosexual Homosexual Bisexual I choose not to answer

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

Have you seen a counselor, psychologist, psychiatrist or other mental health professional before?

No Yes If so:

Name of therapist: _____

Dates of Treatment

Reason for seeking help: _____

Name of therapist: _____

Dates of Treatment

Reason for seeking help: _____

Name of therapist: _____

Dates of Treatment

Reason for seeking help: _____

Are you **CURRENTLY** taking **PSYCHIATRIC** medication? No Yes If YES, please list:

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

Are you **CURRENTLY** taking **NON-PSYCHIATRIC** medication? No Yes If YES, please list:

Medication	Dosage	How long have you been taking it?

Have you been on **PSYCHIATRIC** medication in the past? No Yes If YES, please list:

Medication	Dosage	First/Last time you took it	Effect of Medication

Have you been hospitalized for psychiatric reasons? No Yes If YES, describe:

Hospital	Dates	Reason

Have you ever attempted suicide? No Yes If YES, describe:

MEDICAL HISTORY

Are you **CURRENTLY** under treatment for any medical condition? No Yes If YES, describe:

List any **PRIOR** illnesses, operations and accidents

FAMILY HISTORY

Father: Age: Living
 If deceased, HIS age at time of his death _____
 Occupation: _____
 Frequency of contact with him: _____

Deceased Cause of death: _____
 YOUR age at time of his death _____
 Health: _____
 Are you/Have you been close to him? _____

Mother: Age: Living
 If deceased, HER age at time of her death _____
 Occupation: _____
 Frequency of contact with her: _____

Deceased Cause of death: _____
 YOUR age at time of her death _____
 Health: _____
 Are you/Have you been close to her? _____

Brothers and Sisters

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

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

No Yes If so, please give the persona’s name and relationship to you

Name: _____ Relationship to you: _____

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

	Children	Brothers	Sisters	Father	Mother	Uncle/Aunt	Grandparents
Nervous Problems							
Depression							
Hyperactivity							
Counseling							
Psychiatric Medication							
Psychiatric Hospitalization							
Suicide Attempt							
Death by Suicide							
Drinking Problem							

SOCIAL HISTORY

Past Marital History

Have you been married previously? _____ If Yes, please describe

When? _____

How long? _____

When? _____

How long? _____

Education

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, were/are you on any medication? _____

If so, which medication? _____

What kinds of grades did you get in school? _____

Have you served in the military? _____

If yes, please describe briefly: _____

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

Employment

Are you currently employed? _____

If yes, employer's name: _____

What type of work do you do? _____

Employment History (most recent first)

Type of Job	Dates	Reason for Leaving

Have you been arrested? _____

If yes, please describe: _____

Do you have a religious affiliation? _____

If yes, what is it? _____

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

Please describe: _____

SUBSTANCE ABUSE

Alcohol

Do you drink alcohol? _____ 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? _____

Other Drugs:

Please indicate for each drug listed below

Drug	Ever Used?	Age at 1st use	Time Since Last Use	Approx use in last 30 days
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				

Is there anything else you would like us to know about you?

I affirm that all of the information provided above is true and complete. I agree to promptly advise my provider if any of the above information changes.

_____ /_____/_____
 Client's signature Printed name Date