INTAKE QUESTIONNAIRE

Your responses to the questions in this in this form are strictly confidential and will become part of your medical record.

Name *(Last, First, MI):*				☐ F ☐ M ☐ T	DOB:		
Marital status:	☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed	How Long?
Living with:	☐ Alone	☐ w/Spouse	☐ w/Partner	☐ w/Roommate	☐ w/Parents	☐ Other:	
Primary or referring doctor:				Date of last physical exam:			
Employment:	☐ Full Time	☐ Part Time	☐ Unemployed	☐ Under Employed	☐ Disability	☐ Other:	
Student:	☐ Full Time	☐ Part Time	Grade:				
Education:	☐ High School	☐ GED	☐ 2 Yr College	☐ 4 Yr College	☐ Graduate School	☐ Technical School	☐ Other
Occupation:				Partner's Occupation:			

FAMILY CONSTELLATION

PLEASE PROVIDE THE FOLLOWING INFORMATION AND INCLUDE A ONE WORD "DESCRIPTION" OF EACH PERSON					
	AGE	WRITE A ONE WORD DESCRIPTION		AGE	WRITE A ONE WORD DESCRIPTION
Yourself			Partner	☐ M ☐ F	
Father			Ex-Partner	☐ M ☐ F	
Mother			Ex-Partner	☐ M ☐ F	
Grandmother *Maternal*			Grandmother *Paternal*		
Grandfather *Maternal*			Grandfather *Paternal*		
Sibling name			Children name		
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	

CURRENT SUPPORT SYSTEMS

☐ Close Friends	☐ Group Friends	☐ Family	☐ Extended Family	☐ Religious Group(s)	☐ 12 Step Group(s)
☐ Other					

CHALLENGES

Present psychological difficulties – please check any that apply to you at this time.		
Generalized anxiety	☐ Yes	☐ No
Specific fears / phobias (list):	☐ Yes	☐ No
Panic attacks	☐ Yes	☐ No
Social anxiety	☐ Yes	☐ No
Obsessive thinking or compulsive behaviors (list):	☐ Yes	☐ No
Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)	☐ Yes	☐ No
Sadness or Depression	☐ Yes	☐ No
Emotionally overwhelmed	☐ Yes	☐ No
Frequent crying	☐ Yes	☐ No
Loss of energy	☐ Yes	☐ No
Loss of pleasure in life	☐ Yes	☐ No
Self-injurious / Self-harm behavior	☐ Yes	☐ No
Thoughts of suicide	☐ Yes	☐ No
Problems with eating	☐ Yes	☐ No
Problems falling asleep	☐ Yes	☐ No
Problems sleeping through the night (waking in the middle of the night or early morning)	☐ Yes	☐ No
Trouble waking up	☐ Yes	☐ No
Fatigue / Tiredness during the day	☐ Yes	☐ No
Nightmares	☐ Yes	☐ No
Problems with attention or concentration	☐ Yes	☐ No
Hearing strange voices	☐ Yes	☐ No
Racing thoughts	☐ Yes	☐ No
Memory lapses	☐ Yes	☐ No
Problems making or keeping friends	☐ Yes	☐ No
Problems controlling temper	☐ Yes	☐ No
Physical Illness	☐ Yes	☐ No
Eating disorder	☐ Yes	☐ No
Relationship / Marriage problems	☐ Yes	☐ No
Problems with intimacy	☐ Yes	☐ No
Problems with job	☐ Yes	☐ No
Problems with school	☐ Yes	☐ No
Hopelessness	☐ Yes	☐ No
History of abuse (emotional, physical, sexual)	☐ Yes	☐ No
Alcohol / Drug use or abuse	☐ Yes	☐ No
Financial Problems	☐ Yes	☐ No
Legal situation	☐ Yes	☐ No
Grief / Mourning	☐ Yes	☐ No
Pain	☐ Yes	☐ No
Hallucinations	☐ Yes	☐ No
Guilt	☐ Yes	☐ No

Worry	☐ Yes	☐ No
Mood swings	☐ Yes	☐ No
Codependency	☐ Yes	☐ No
Repetitive thoughts	☐ Yes	☐ No
Loneliness	☐ Yes	☐ No
Perfectionism	☐ Yes	☐ No
Rapid speech	☐ Yes	☐ No
Impulsiveness	☐ Yes	☐ No

POSITIVE QUALITIES

Which of these qualities do you feel you 'have'?						
Creativity	☐	Yes	☐	No	☐	Sometimes
Curiosity	☐	Yes	☐	No	☐	Sometimes
Love of learning	☐	Yes	☐	No	☐	Sometimes
Wisdom / perspective	☐	Yes	☐	No	☐	Sometimes
Bravery	☐	Yes	☐	No	☐	Sometimes
Persistence	☐	Yes	☐	No	☐	Sometimes
Integrity	☐	Yes	☐	No	☐	Sometimes
Vitality	☐	Yes	☐	No	☐	Sometimes
Love	☐	Yes	☐	No	☐	Sometimes
Kindness	☐	Yes	☐	No	☐	Sometimes
Social Intelligence	☐	Yes	☐	No	☐	Sometimes
Fairness	☐	Yes	☐	No	☐	Sometimes
Leadership	☐	Yes	☐	No	☐	Sometimes
Forgiveness / Mercy	☐	Yes	☐	No	☐	Sometimes
Humility / Modesty	☐	Yes	☐	No	☐	Sometimes
Self-control	☐	Yes	☐	No	☐	Sometimes
Appreciation of beauty / excellence	☐	Yes	☐	No	☐	Sometimes
Gratitude	☐	Yes	☐	No	☐	Sometimes
Hope	☐	Yes	☐	No	☐	Sometimes
Humor / Playfulness	☐	Yes	☐	No	☐	Sometimes
Spirituality	☐	Yes	☐	No	☐	Sometimes

PREVIOUS TREATMENT

Are you currently seeing a therapist? (Name/ contact phone #)
Have you ever seen a psychiatrist/ psychotherapist before?: ☐ Yes ☐ No
Have you ever been treated for any of the following: (check all that apply)

☐	Bipolar (Manic/Depressive) Disorder	☐	Depression	☐	ADHD
☐	Anxiety	☐	OCD	☐	Schizophrenia
☐	Panic Attacks	☐	PTSD	☐	Alcohol Problems (including AA)
☐	Anorexia/Bulimia/Binge-eating	☐	ECT treatment	☐	Drug Problems

Please list in chronological order all prior psychiatric hospitalizations or treatment centers

Approximate Date	Length of Stay	Name of Hospital	Reason for Admission

Have you ever attempted to harm/kill yourself? If so, please list the occurrences below: Never

Approximate Date	How did you attempt (method)?

Please list ***all*** current medications below (include birth control pills, over the counter medication and herbal remedies – ie: decongestants, St. John's Wort, etc.).

Name of Medication	Dosage (mg)	How many times a day	On this for how long?	Side effects (if any)	Prescribing physician

FAMILY HISTORY

Has anyone in the birth family had any of the following psychological disorders? Check all that apply and list who (self, mother, father, sibling, child).

Yes	Condition	Family Member
	Mental Retardation	
	Speech or Communication Disorder	
	Attention-Deficit /Hyperactivity / Impulsivity	
	Learning Problems / Disabilities	
	Autism Spectrum / Asperger's Disorder	
	Sleep Disorders	
	Generalized Anxiety (across many situations)	
	Social Anxiety	
	Obsessive-Compulsive Disorder	
	Phobias	
	Depression	
	Manic-Depression / Bipolar Disorder	
	Suicide attempts / Suicide	
	Schizophrenia or other psychosis	

	Alcohol / Substance Abuse	
	Seizures or other neurological disorder	
	Genetic Disorder (e.g.; Down Syndrome, Fragile X)	
	Other:	

Have you experienced in the past or currently have any of the following medical difficulties:

☐	Chronic Illness	☐	Chronic Pain	☐	Arthritis
☐	Diabetes	☐	Auto Immune Disease	☐	High Blood Pressure
☐	Low Blood Pressure	☐	Thyroid	☐	Migraines
☐	Infertility	☐	Erectile Dysfunction	☐	Seizures
☐	Gastrointestinal	☐	Cancer	☐	Genetic Disorder

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to “binge” drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks/day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

DRUGS OF CHOICE						
Please provide the following information as it applies to you for the following substances:						
	Never Used	Age first used	Date last used	Age at peak use	History of abuse	Current use/frequency
Cocaine						
Amphetamines / Speed / Adderall						
Cannabis						
Diet Pills						
Hallucinogens (LSD, mushrooms, Mescaline)						
Ecstasy						
Diuretics						
Tranquilizers						
Khat / Bath Salts						
Pain Pills (Vicodin, Oxycontin, Dilaudid, Percocet, etc.)						
Laxatives						
Tobacco or “vape”						
Adderall						
PCP or Angel Dust						
Spice / K2						
IV Drug use						
Heroin						
GHB / Rohypnol						
Anabolic Steroids						
Caffeine (Coffee, Tea, Cola, Iced tea, Energy Drinks)						
Inhalants						
Benzodiazepines (Xanax, valium, Ativan, Restoril, Librium)						

Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No

Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ NO

CHILDHOOD

☐	Happy Childhood	☐	Neglected / Isolated	☐	Physical Abuse
☐	Sexual Abuse	☐	Alcohol in family	☐	Drugs in family
☐	Mental health issues in family	☐	Conflict & Fighting	☐	Divorce
☐	Remarriage	☐	Step Siblings	☐	Frequent Moves
As a child you were: (check all that apply)					
☐	Given direction	☐	On your own	☐	Silent
☐	Anxious	☐	Depressed	☐	Talkative
☐	Good Grades	☐	Poor Grades	☐	Sad
☐	Popular	☐	Few Friends	☐	Angry
☐	Spoiled	☐	Neglected		
As a child did you experience: (check all that apply)					
	Verbal Abuse		Physical Abuse		Threats to self or others
	Abandonment		Necessities withheld		Had to be the 'grownup'
	Sudden death of a relative		Accidents to self or others		Illnesses of self or others
	Witness violence		Inappropriately touched		Incest
	Rape				

What is your mood right now:					
	Euphoric		Elated		Cheerful
	Tranquil		Calm		Anxious
	Panicky		Fearful		Worried
	Enraged		Angry		Agitated
	Apathetic		Depressed		Remorseful
	Hopeless		Suicidal		Hopeful

WHY HERE – WHY NOW?

Describe your reason for coming today & why now?

	Mood State		Relationship Issue		Employment
	Substance Use		Medical Issue		Recent life event

Why here – why now?

Who else needs to be involved?

What are your goals?