Mankato Mental Health Associates

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INTAKE QUESTIONNAIRE (ADULT)

The following questionnaire is designed to assist you and me in developing and carrying out the type of service which seems most appropriate for you. If you don't wish to answer a question or if it doesn't apply to you, simply write the letters **NA** (Not Applicable). If you don't know or can't remember, write the letters **DK** (Don't Know). Please remember that this document, like all others in your file, is confidential and cannot be released without your written consent.

1. GENERAL INFORMATION

Full Name______________________________________Age________________Today's Date________________

How did you hear about us?____

Please describe your reason(s) for seeking assistance:

When did these issues become a problem?

What have you already tried? What was the result?

2. OCCUPATIONAL/EDUCATIONAL/RECREATIONAL INFORMATION

Highest grade completed/current grade_____________________School__________________________________

Your adjustment to school was: ☐Excellent ☐Good ☐Fair ☐Poor

Favorite subjects__________________________Least favorite subjects___________________________________

Current employer__________________________Number of years there___________________________________

Previous work____

What do you do with your free time?____

Do you have many friends or social groups?____

Are you a veteran?____

3. CURRENT FAMILY INFORMATION

Current marital status (and partner's name, if applicable): ____

Children and ages:____

Have you been married before? YES NO If so, how many times?_______________

I currently live with:____

Have you experienced any abuse in your relationships? YES NO

4. **FAMILY OF ORIGIN**

Mother's name:____Age:__________________

Occupation:_________________________________Marital status:______________________

Father's name:____Age:__________________

Occupation:_________________________________Marital status:______________________

Number of siblings and ages:____

While growing up were you:

Happy with the way you were raised?	YES	NO
Treated cruelly, beaten, or mistreated?	YES	NO
Sexually abused?	YES	NO
Adopted?	YES	NO
In foster care at any point?	YES	NO

Is there a history of any of the following in your family?

- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar
- ☐ Psychosis
- ☐ ADHD
- ☐ Bipolar disorder
- ☐ Eating disorder
- ☐ Substance abuse
- ☐ Suicide
- ☐ Psychiatric hospitalization

Was there anything unusual about your birth?	YES	NO
Did your mother drink, smoke, or use drugs while pregnant with you?	YES	NO
Were there any medical difficulties for you when you were an infant?	YES	NO

If yes, what?____

Did you experience any accidents causing injury to you? YES NO

If yes, what?____

5. **MEDICAL/HEALTH INFORMATION**

Name of primary physician and clinic____

Date of most recent physical exam____

Are you wanting us to collaborate with your doctor?_______________________________

Surgeries____

Hospitalizations____

Allergies____

Head injuries____

Are you currently suffering from any medical conditions? YES NO

If so, what conditions____

What medications are you currently on?_______________________________________

____

How good is your sleep each night? ____

How many hours of sleep do you get?____

How many times a day do you eat a meal?_____________________________________

How many times a day do you eat fruits/vegetables?______________________________

How much physical activity do you get each day?________________________________

6. **MENTAL HEALTH INFORMATION**

Have you ever had mental health treatment before? YES NO

If so, please list names of therapists, dates of therapy, and which agencies you've used

____

____

Have you ever been hospitalized for a mental health problem? YES NO

If so, please list dates and hospitals____

____

Have you *recently* had thoughts of killing yourself? YES NO

Have you ever made plans or attempted to kill yourself? YES NO

Are you currently taking a medication for mental health reasons? YES NO

If so, please list the medication name(s) and dosage(s)________________________________

____

Prescriber of medication(s)____

Any past mental health medications?____

7. LEGAL HISTORY

Have you ever been: ☐On probation ☐In jail ☐In prison ☐On parole

If so, when and why?____

8. CHEMICAL USE HISTORY

Have you ever been treated for drug or alcohol abuse? YES NO

If so, where?________________________When________________________

	Current Amount Used	Use in Past	Age First Used
Caffeine			
Tobacco			
Alcohol			
Marijuana			
Other			
Other			

Drug of choice (if any)____

	YES	NO
Have you ever felt like you ought to cut down on your drinking or drug use?	☐	☐
Have you ever had people annoy you by criticizing your drinking or drug use?	☐	☐
Have you ever felt bad or guilt about your drinking or drug use?	☐	☐
Have you ever had a drink or used drugs as an eye opener first thing in the morning to steady your nerves, get rid of a hangover, or to get the day started?	☐	☐
Have you struggles with any other compulsive behaviors (i.e., gambling, pornography, video games)?	☐	☐

9. RELIGION/SPIRITUALITY

Religious or spiritual identity:____

Are you actively practicing? YES NO

10. OTHER IMPORTANT INFORMATION

Is there anything else important you feel we should know about who you are?

11. **SYMPTOM REVIEW**

Please check any of the following that have applied to you in the past two weeks. Use a question mark if you're not sure.

- ☐ Weight loss without dieting
- ☐ Significant weight gain
- ☐ Cry often and easily
- ☐ Feel so good/hyper, others say I'm not myself
- ☐ I'm usually very talkative
- ☐ I've been more talkative than normal
- ☐ Speaking faster than usual
- ☐ Sleeping much less and not missing it
- ☐ Racing thoughts
- ☐ More energy than usual
- ☐ More social/outgoing than usual
- ☐ Taking risky or regrettable actions
- ☐ Problems from spending money
- ☐ More sexual than usual
- ☐ Inattentive/easily distracted
- ☐ Impulsive
- ☐ Often fidget
- ☐ Fail to finish things
- ☐ Bad memory/forget things a lot
- ☐ Bad at organizing
- ☐ Procrastinate
- ☐ Get in physical fights
- ☐ Infections
- ☐ Vision problems
- ☐ Severe headaches
- ☐ Chronic pain
- ☐ Sexual difficulties
- ☐ Hearing problems
- ☐ High blood pressure
- ☐ Seizures
- ☐ Sleep walking
- ☐ Dizziness
- ☐ Nervous habits
- ☐ Nail biting
- ☐ Skin picking
- ☐ Chronic neck/back tension or pain
- ☐ Panic attacks
- ☐ Fear of large public places
- ☐ Flashbacks
- ☐ Easily startled
- ☐ Tics
- ☐ Many physical complaints
- ☐ Quick mood changes
- ☐ Often daydreaming
- ☐ Difficulty making decisions
- ☐ Sometimes confused about who I am
- ☐ Sometimes confused about where I am
- ☐ Stubborn
- ☐ Too few friends
- ☐ Withdrawn
- ☐ Overly shy
- ☐ Tense
- ☐ Touchy
- ☐ Submissive
- ☐ Show off/center of attention
- ☐ Follower
- ☐ Easily embarrassed
- ☐ Clumsy/careless
- ☐ Odd/strange behavior
- ☐ Repeated actions I can't stop
- ☐ Repeated thoughts I can't stop
- ☐ Nightmares
- ☐ Perfectionistic
- ☐ Seeing things others don't
- ☐ Hearing things others don't
- ☐ Eat non-food items

1. Are you unable to use any parts of your home for their intended purposes? For example: cooking, using, furniture, washing dishes, sleeping in bed, etc.?

2. Have you ever been in an argument with a loved one because of the clutter in your home?

PHQ-9

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems? *(Circle to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

GAD-7

Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems? *(Circle to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3