WILLOWBROOK
MENTAL HEALTH

New Adult Patient Intake

Name: (First)_____ (Last)_____

Mental Health Questionnaire

Please describe your goals for treatment:

_____

_____

_____

_____

Please describe what factors or events have lead you to seeking treatment at this specific time:

_____

_____

_____

_____

The information you provide your clinician is confidential and voluntary. The following questions provide important information to understand you and planning efforts. We appreciate your response. If your selection does not appear as an option, please specify your answer in the space provided at the end.

☐ I am comfortable communicating electronically via email.

☐ I am ***not*** comfortable communicating electronically via email

☐ I am comfortable communicating electronically via text (appointment reminders/scheduling communication only)

☐ I am ***not*** comfortable communicating electronically via text (appointment reminders/scheduling communication only)

How did you hear about us?_____

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Previous Treatment History

Have you been to counseling/therapy before? ☐ Yes / ☐ No

If yes, Name of therapist or clinic: _____

How long ago (start dates & duration of the therapy): _____

What was the presenting issue you were seeking therapy for at that time? _____

Was it beneficial? ☐ Yes / ☐ No Reason for termination: _____

Have you had any inpatient treatment for mental health? ☐ Yes / ☐ No

If yes, When? _____ Was it beneficial? Yes / No

Name of facility: _____

Suicide Risk Screen

Suicidal Thoughts ☐ None ☐ Yes, Recently ☐ Yes, In the Past

Suicidal Attempts ☐ None ☐ Yes, Recently ☐ Yes, In the Past

Suicidal Threats ☐ None ☐ Yes, Recently ☐ Yes, In the Past

If yes to any of these, please explain the nature of the thoughts, attempts, and/or threats:

_____

Relationship Information

☐ Single (never married) ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Engaged

Name of Current Spouse/Significant Other: (First)_____(Last)_____

Years married/together: _____

Name of Previous Spouse: (First)_____(Last)_____Years married/together: ____

Name of Previous Spouse: (First)_____(Last)_____Years married/together: ____

Child Information

Child's Name: _____ Age _____

Other Biological Parent:_____ Does child live in your home? ☐ Yes ☐ No

Child's Name: _____ Age _____

Other Biological Parent:_____ Does child live in your home? ☐ Yes ☐ No

Child's Name: _____ Age _____

Other Biological Parent:_____ Does child live in your home? ☐ Yes ☐ No

Child's Name: _____ Age _____

Other Biological Parent:_____ Does child live in your home? ☐ Yes ☐ No

Child's Name: _____ Age _____

Other Biological Parent:_____ Does child live in your home? ☐ Yes ☐ No

Current Living Arrangements

(Please choose all that apply)

☐ Housing Adequate ☐ Overcrowded ☐ Homeless ☐ Dysfunctional ☐ Dependent on others for housing

Please list persons currently living in household:

Name:_____ Age: ____ Relationship to Patient: _____

Name:_____ Age: ____ Relationship to Patient: _____

Name:_____ Age: ____ Relationship to Patient: _____

Name:_____ Age: ____ Relationship to Patient: _____

Parental Information

Please indicate the current marital status of your parents *(choose all that apply)*:

☐ Never Married ☐ Divorced ☐ Currently Married ☐ Mother Remarried ☐ Father Remarried

Please describe your current relationship with your mother *(choose all that apply)*?

☐ Good ☐ Mixed ☐ Poor ☐ Never Present ☐ Deceased : Age of patient at mother's death: _____

Please describe your current relationship with your father *(choose all that apply)*?

☐ Good ☐ Mixed ☐ Poor ☐ Never Present ☐ Deceased : Age of patient at mother's death: _____

At what age did you leave home? _____

What was your reason for leaving home *(choose all that apply)*?

☐ School/College ☐ Poor Home Environment ☐ Got Married ☐ Needing Independence

☐ Other: _____

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Sibling Information

Birth order: I am the _________ (st/nd/rd/th) sibling in a line of _____________ siblings.

Sibling Name: ______________________________________ ☐ Full Sibling ☐ Half Sibling ☐ Step Sibling

How is your current relationship with this sibling? ☐ Good ☐ Mixed ☐ Poor ☐ Deceased ☐ Not Present

Sibling Name: ______________________________________ ☐ Full Sibling ☐ Half Sibling ☐ Step Sibling

How is your current relationship with this sibling? ☐ Good ☐ Mixed ☐ Poor ☐ Deceased ☐ Not Present

Sibling Name: ______________________________________ ☐ Full Sibling ☐ Half Sibling ☐ Step Sibling

How is your current relationship with this sibling? ☐ Good ☐ Mixed ☐ Poor ☐ Deceased ☐ Not Present

Sibling Name: ______________________________________ ☐ Full Sibling ☐ Half Sibling ☐ Step Sibling

How is your current relationship with this sibling? ☐ Good ☐ Mixed ☐ Poor ☐ Deceased ☐ Not Present

Sibling Name: ______________________________________ ☐ Full Sibling ☐ Half Sibling ☐ Step Sibling

How is your current relationship with this sibling? ☐ Good ☐ Mixed ☐ Poor ☐ Deceased ☐ Not Present

Childhood Information

Please choose all that apply.

☐ Outstanding Home Environment ☐ Normal Home Environment ☐ Chaotic or Poor Home Environment ☐ Witnessed Abuse Experienced Abuse ☐ Moved Often ☐ Neglected ☐ Traumatic Event ☐ Did Not Live With Parents ☐ Foster Care ☐ Homelessness ☐Other: ____

Social Questionnaire

Please choose all that apply.

Support System: ☐ Supportive Friends ☐ No or Few Friends ☐ Unsupportive Friends ☐ Substance-use-based friends ☐ Supportive Family Unsupportive Family ☐ Distant from Family ☐ Supportive Significant Other ☐ Unsupportive Significant Other ☐ Supportive work ☐ Religious/spiritual organization

☐ Other: ____

Sexual History: ☐ Homosexual ☐ Bisexual ☐ Heterosexual ☐ Other: _________________________

Gender: ☐ Female ☐ Male ☐ Non-Binary ☐ Other: ___________________________________

Social Activities *Please choose all that apply.*

☐ Enjoy Volunteering ☐ Member of a Church ☐ Attend Church Groups ☐ Attend Support Groups ☐ Friends ☐ Attend Goodwill or Other Day Service / Other: _____

Hobbies: _____

Race Background

Please choose all that apply.

☐ African American/Black ☐ American Indian/Alaskan Native ☐ Asian/Asian American ☐ Caucasian/White

☐Hispanic/Latino ☐ Multiracial ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

Religion

☐ Agnostic ☐ Atheist ☐ Buddhist ☐ Catholic ☐ Hindu ☐ Jewish ☐ Muslim ☐ Protestant

☐ Non-Religious ☐ Other: _____

Substance Abuse Risk Screen

Please choose all that apply.

Do you currently drink alcohol or use drugs? ☐ Yes ☐ No

Mark any of the following drugs you have taken, indicating present or past use.

☐ None ☐ Tobacco (☐ present ☐ past) ☐ Marijuana (☐ present ☐ past)

☐ Prescription opiates (☐ present ☐ past) ☐ Street opiates (☐ present ☐ past)

☐ Street amphetamines (☐ present ☐ past) ☐ Prescribed stimulant (☐ present ☐ past)

☐ Hallucinogens (☐ present ☐ past) ☐ Prescribed/street benzodiazepines (☐ present ☐ past)

☐ MDMA (☐ present ☐ past) ☐ Inhalants (☐ present ☐ past)

☐ Other: _____

Alcohol (☐ present ☐ past)

If yes, how many alcoholic beverages do you consume in an average day? _____ week? _____

Have you ever felt you should cut down on drinking or drug use? ☐ Yes ☐ No

Have friends or family annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No

Have you ever felt bad or guilty about drinking or drug use? ☐ Yes ☐ No

Have you ever drank or used drugs in the morning to steady your nerves or get rid of a hangover? ☐ Yes ☐ No

Have relationships with friends/family members been negatively influenced by drinking/drug use? ☐ Yes ☐ No

Have you had treatment for alcohol or drug abuse in the past? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes, How much per day: _____

Mental Health Symptoms

Please choose all that apply.

	Just Recently	In the Last Year	Several Years	Most of My Life
Low energy				
Depression				
Waking up at night				
Trouble falling asleep				
Sleeping too much				
Low self-esteem				
Self-harm				
Crying often				
Feeling guilty or shameful				
Feeling worthless				
Loss of interest				
Isolating from others				
Sadness/Loss				
Anxiety/fears				
Worries/mind racing				
Repeating actions				
Loss of focus				
Hyper – too much energy				
Mood swings				
Difficulty concentrating				
Anger/temper issues				
Physical chronic pain				
Weight change				
Appetite change				
Stomach issues				
Frequent headaches				
Constipation/diarrhea				
Gambling issues				
Financial stress				

	Just Recently	In the Last Year	Several Years	Most of My Life
Impulsiveness				
Substance abuse issues				
Sexual problems				
Nightmares				
Family violence				
Physical abuse				
Sexual abuse				
Inappropriate sexual behaviors				
Perpetrator of abuse				
Employment issues				
Troubles at school				
Parent/child conflict				
Relationship issues				
Family conflict				

Employment/Disability Information

Please choose all that apply.

☐ Disabled (Mental Disability) ☐ Disabled (Physical Disability) ☐ Employed (Full) ☐ Employed (Part-time) ☐ Retired

☐ Self-employed ☐ Student ☐ Unemployed (No disability) ☐ None of these

Who is your current employer? _____

What is your current position at your job? _____

How long have you been unemployed and/or disabled? _____

Military Information

Please choose all that apply.

☐ No History ☐ Currently Serving ☐ Honorably Discharged ☐ Other Than Honorably Discharged ☐ General Discharge

☐ Bad Conduct Discharge

How many years did you serve? _____

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Legal Information

Please choose all that apply.

☐ No Legal History ☐ Substance Related Charges ☐ Court Ordered Therapy ☐ Felony Charges

☐ Domestic/Assault Charges

☐ Arrested - *Number of times*: _____ / Jail Time Served - *Number of times*: _____

Currently on ☐ Probation ☐ Parole

Education Information

Please choose all that apply.

Learning Disabilities ☐ Yes ☐ No

Special Education ☐ Yes ☐ No

Alternative School: ☐ Yes ☐ No *If Yes, Name of School:* _____

Suspended, Expelled, Retained ☐ Yes ☐ No Last Grade Completed: _____

Name of High School Attended: _____ Did you graduate? ☐ Yes ☐ No

Name of College Attended: _____ Degree Obtained: _____

Name of College Attended: _____ Degree Obtained: _____

Name of College Attended: _____ Degree Obtained: _____

Medical Information

Were you born prematurely: ☐ Yes ☐ No *If yes*, how many weeks early?: _____

Did your mother have any difficulties during the pregnancy or birth? ☐ Yes ☐ No

Did your mother use alcohol, tobacco, or other drugs during pregnancy? ☐ Yes ☐ No

Developmental Milestones:

☐ Above Average (ex: walked and talked before most)

☐ Average (ex: walked and talked at the same level as peers)

☐ Below Average (ex: walked and talked later than most)

Have you or any family member been diagnosed with any of the following:

	Myself	Child	Parent	Grandparent
Diabetes:				
Head Injury/TBI				
Thyroid Disease:				
HIV/AIDS				
Stroke				
Birth Defects				
Cancer				
Heart Disease				
High Blood Pressure				
Alzheimer's/Dementia				

Have you or any family member been diagnosed with any of the following:

	Myself	Parent	Grandparent	Sibling	Child
Depression					
Anxiety					
ADD/ADHD					
PTSD					
Autism					
Conduct Disorder					
Eating Disorders					
Schizophrenia					
Substance Abuse Disorder					
Personality Disorder					
Obsessive-Compulsive Disorder					
Bipolar Disorder					
Learning Disorder					
Infertility					
Other					

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Current Medications

Are you currently taking any medications? ☐ Yes ☐ No

Allergies: _____

Please list all medications that you are currently taking:

Medication	Dose (mg)	Prescribing Doctor	What is it for?	Side Effects?	Beneficial?

If you are taking more medications, please include them in the space at the end of the form.