# 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**

Difficulty falling asleep Difficulty getting out of bed

Average hours of sleep per night:

Difficulty staying asleep

Not feeling rested in the morning

Persistent loss of interest in previously enjoyed activities

Withdrawing from other people Spending increased time alone

Depressed Mood Feeling Numb

Rapid mood changes Irritability

Anxiety Panic attacks

Frequent feelings of guilt Avoiding people, places, activities or specific things Difficulty leaving your home

Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)

Outbursts of anger

Worthlessness Hopelessness

Sadness Helplessness

Fear Feeling or acting like a different person

Changes in eating/appetite

Eating more Eating less

Voluntary vomiting Use of laxatives Excessive exercise to avoid weight gain Binge eating Are you trying to lose weight?

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | | |
|  | Weight gain: lbs |  | Weight loss: lbs. |
|  | Difficulty catching your breath |  |  |

Unusual sweating Increased energy Tremor

Frequent worry Racing thoughts

Increase muscle tension

Easily started, feeling “jumpy” Decreased energy

Dizziness

Physical sensations others don’t have 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 Difficulty meeting role expectations

Dependency on others Manipulation of others to fulfill your own desires

Inappropriate expression of anger Self-mutilation/cutting Difficulty or inability to say “no” to others Ineffective communication

Sense of lack of control Decreased ability to handle stress

Abusive relationship Difficulty expression emotions Concerns about your sexuality

## 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:

Yes If YES, please list:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Are you **CURRENTLY** taking **PSYCHIATRIC** medication? | | |  | No | |  |  |
| **Medication** | **Dosage** | **How long have you been taking it?** | | | **Has it been helpful?** | | |
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Yes If YES, please list:

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| --- | --- | --- | --- | --- | --- | --- |
| Are you **CURRENTLY** taking **NON-PSYCHIATRIC** medication? | | |  | No |  |  |
| **Medication** | **Dosage** | **How long have you been taking it?** | | | | |
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Yes If YES, please list:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Have you been on **PSYCHIATRIC** medication in the past? | | |  | No | |  |  |
| **Medication** | **Dosage** | **First/Last time you took it** | | | **Effect of Medication** | | |
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| --- | --- | --- | --- | --- | --- | --- |
| Have you been hospitalized for psychiatric reasons? | | |  | No |  | Yes If YES, describe: |
| **Hospital** | **Dates** | **Reason** | | | | |
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**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

Deceased Cause of death:

If deceased, HIS age at time of his death YOUR age at time of his death Occupation: Health: Frequency of contact with him: Are you/Have you been close to him?

***Mother:*** Age:

Living

Deceased Cause of death:

If deceased, HER age at time of his death YOUR age at time of his death Occupation: Health: Frequency of contact with him: 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** |

**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** |
|  |  |  |
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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?**

# 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** |  |
| Death of Spouse | 100 |  |
| Divorce | 73 |  |
| Marital Separation | 65 |  |
| Gone to jail | 63 |  |
| Death of close family member | 63 |  |
| Personal injury or illness | 53 |  |
| Marriage | 50 |  |
| Fired at work | 47 |  |
| Marital reconciliation | 45 |  |
| Retirement | 45 |  |
| Change in health of family  member | 44 |  |
| Pregnancy | 40 |  |
| Sexual Difficulties | 39 |  |
| Gain of new family member | 39 |  |
| Business readjustment | 39 |  |
| Change in financial state | 38 |  |
| Death of a close friend | 37 |  |
| Change to different line of work | 36 |  |
| Increase in arguments with  spouse | 35 |  |
| Mortgage over $100,000 | 31 |  |
| Foreclosure of mortgage or loan | 30 |  |
| Change in responsibilities at  work | 29 |  |

|  |  |  |
| --- | --- | --- |
| **Life Events** | **Life Crisis**  **Units** |  |
| Son or daughter leaving home | 29 |  |
| Trouble with in-laws | 29 |  |
| Outstanding personal achievement | 28 |  |
| Spouse begins or stops work | 26 |  |
| Begin or end school | 26 |  |
| Change in living conditions | 25 |  |
| Revision in personal habits | 24 |  |
| Trouble with boss | 23 |  |
| Change in work hours or conditions | 20 |  |
| Change in residence | 20 |  |
| Change in schools | 20 |  |
| Change in recreation | 19 |  |
| Change in church activities | 19 |  |
| Change in social activities | 18 |  |
| Mortgage or loan less than $30,000 | 17 |  |
| Change in sleeping habits | 16 |  |
| Change in number of family get-  togethers | 15 |  |
| Change in eating habits | 15 |  |
| Vacation | 13 |  |
| Christmas alone | 12 |  |
| Minor violations of the law | 11 |  |

## Your Total Score: