Intake Mental Health Questionnaire

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 staying asleep
- ☐ Difficulty getting out of bed
- ☐ Not feeling rested in the morning

Average hours of sleep per night: _____

- ☐ 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	☐ Increase muscle tension
☐ Unusual sweating	☐ Easily started, feeling "jumpy"
☐ Increased energy	☐ Decreased energy
☐ Tremor	☐ Dizziness
☐ Frequent worry	☐ Physical sensations others don't have
☐ Racing thoughts	☐ Intrusive memories
☐ Difficulty concentrating or thinking	☐ Large gaps in memory
☐ Flashbacks	☐ Nightmares
☐ Thoughts about harming or killing yourself	☐ 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: _____ _____

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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 ☐ 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

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?

How much do you drink? How often do you drink? _____

If yes, age of first use _____

_____

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?