PATIENT INTAKE QUESTIONNAIRE (ADULT)

(Confidential)

Date Completed: ____/____/_____ **Completed By**: _____

Patient Name_____**DOB:**_____/_____/_____

Preferred Name: _____

Gender _____ **Race/Ethnicity** _____

How did you hear about our clinic? _____

What is the current problem that brings you to the clinic?

_____

_____

_____

_____

How long has this been going on? _____

What would you like to accomplish? _____

_____

_____

_____

Are you requesting any of the following?

Medication *(MD; NP; PA)* [ ] Yes [ ] No

Psychotherapy *(LCPC, LCSW, LMFT)* [ ] Yes [ ] No

Psychological Testing *(Psy.D. and Ph.D.)* [ ] Yes [ ] No

PREVIOUS PSYCHIATRIC TREATMENT

COUNSELING/PSYCHOTHERAPY (Licensed Clinic Professional Counselor (LCPC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), or Psychologist)

Have you ever participated in Counseling and/or Therapy in the past? [ ] Yes [ ] No

Therapist Name: _____ Approximate Year: _____

Therapist Name: _____ Approximate Year: _____

Therapist Name: _____ Approximate Year: _____

Have you ever been diagnosed with a psychiatric diagnosis in the past? [ ] Yes [ ] No

If yes, please list: _____

_____

Have you ever received a psychological evaluation in the past? [ ] Yes [ ] No
If yes, please list: _____
_____

Have you ever been psychiatrically hospitalized? [ ] Yes [ ] No

If yes, where and when: _____

MEDICATION MANAGEMENT (psychiatrist or primary care provider (PCP) prescribing psychiatric medication)
Have you ever taken medication to help you with any psychological/psychiatric symptoms? [ ] Yes [ ] No

If yes, please list all current and past psychiatric medications:

Medication Name	**Reason for taking**	**Prescribing provider**	**Year(s) taken**

FAMILY MENTAL HEALTH HISTORY
In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

		List Family Member
Alcohol Use/Abuse	[ ] Yes [ ] No	_____
Drug Use/Abuse	[ ] Yes [ ] No	_____
Anxiety	[ ] Yes [ ] No	_____
Depression	[ ] Yes [ ] No	_____
Bipolar Disorder	[ ] Yes [ ] No	_____
Eating Disorder	[ ] Yes [ ] No	_____
Obsessive/Compulsive	[ ] Yes [ ] No	_____
Schizophrenia/Psychosis	[ ] Yes [ ] No	_____
ADHD	[ ] Yes [ ] No	_____
Suicide Attempts	[ ] Yes [ ] No	_____
Suicide Completion	[ ] Yes [ ] No	_____
Psychiatric Hospitalizations	[ ] Yes [ ] No	_____

CURRENT ALCOHOL/SUBSTANCE USE

Alcohol: One drink =  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

MEN: How many times in the past year have you had 5 or more drinks in a day? None [ ] 1 or more [ ]
WOMEN: How many times in the past year have you had 4 or more drinks in a day? None [ ] 1 or more [ ]

Substances: (Recreational drug use methamphetamines (speed, crystal); cannabis (marijuana, pot); inhalants (paint thinner, aerosol, glue); tranquilizers (valium; benzodiazepines); barbiturates; cocaine; ecstasy; hallucinogens (LSD, mushrooms); or narcotics)
How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons? None [ ] 1 or more [ ]

SUBSTANCE USE HISTORY

Please indicate substances currently used (over the past 30 days); how much at one time, how many times per day/week, and/or history of use; age of first use, time since last use, length of time used, and method of use.

	Last 30 Days		Past Use			
Substance	**How much at one time**	**How many times per day/week**	**Age of first use**	**Length of time used**	**Time since last use**	**Method of use (IV, Snort, Smoke)**
Caffeine/Energy Drinks						
Nicotine						
Alcohol						
Narcotic Pain Medications						
Steroids						
Anti-anxiety medications						
Sleep medications						
Weight Loss Medications						
Marijuana						
Ecstasy						
Cocaine/Crack						
Heroin						
Methamphetamine						
PCP/LSD/Mushrooms						

Do you believe you have a problem controlling your behavior in any of the following areas?
___ Gambling ___ Sex ___ Drugs ___ Alcohol ___ Shopping/spending money ___ Eating

Have you ever been treated for any of the above conditions? [ ] Yes [ ] No
If yes, was it [ ] voluntary or [ ] mandatory? Number of times? _____
Please describe treatment and outcome_____
_____

MEDICAL / SURGICAL HISTORY
Do you see any medical specialist? [ ] Yes [ ] No
If yes, please list provider's name and what you see them for: _____
_____

MEDICAL HISTORY

[ ] History of Head Injury	[ ] Epilepsy/Seizures	[ ] Stroke
[ ] Headaches/Migraines	[ ] Ear Issues	[ ] Eye Issues
[ ] Sinus Issues	[ ] Mouth/Throat Issues	[ ] Respiratory Problems
[ ] Emphysema/Asthma	[ ] Muscle Problems	[ ] Heart Disease
[ ] High Blood Pressure	[ ] Rheumatic Fever	[ ] Bladder/Kidney Problems
[ ] Hepatitis	[ ] Thyroid: __Hypo __Hyper	
[ ] STDs	[ ] HIV/AIDS	[ ] Arthritis
[ ] Autoimmune Diseases	[ ] Genetic Conditions	[ ] Cancer
[ ] Diabetes	[ ] Sleep Apnea	[ ] Hormonal Issues
[ ] Skin Issues	[ ] Intestinal Issues	[ ] High Cholesterol
[ ] Menopause	[ ] Other:	

Please describe if you checked any of the above conditions:
_____
_____

MEDICATION ALLERGIES [ ] Yes [ ] No

Medication Name _____ Allergic Reaction_____

Medication Name _____ Allergic Reaction_____

Medication Name _____ Allergic Reaction _____

Please list any other allergies you may have (food, seasonal, environmental):_____
_____

CURRENT MEDICATIONS may list here or provide list (including over the counter (OTC), Herbal medications, and Natural Remedies) **Use back of page if more room is needed**

Medication Name _____ Dose/ Frequency _____

Medication Name _____ Dose/ Frequency _____

Medication Name _____ Dose/ Frequency _____

Any chance of being currently pregnant? [ ] Yes [ ] No
Number of:

Pregnancies _____ Live Births _____ Abortions _____ Miscarriages _____

Have you been tested for HIV/Hepatitis C? [ ] Yes [ ] No

SURGICAL HISTORY/HOSPITALIZATIONS:

_____
_____
_____

Do you have chronic pain? [ ] Yes [ ] No Where? _____

Average pain level (0-10; 0=no pain, 10=worst ever)? _____

How long have you suffered with chronic pain? _____

DEVELOPMENTAL HISTORY: Were you early, normal or late on any of the following developmental milestones?
Sitting _____ Walking_____ Talking_____ Potty Training_____

Did you have any developmental delays growing up (i.e. learning delays, speech delays, etc.)? If so, please explain:_____

Have you ever received treatment for developmental delays? Please explain:

_____
_____

PSYCHOSOCIAL HISTORY
Where do you currently live (house, apartment, group home etc.)? _____

Who currently lives with you? _____

Who do you consider as your primary emotional supports? _____

_____

How do you currently meet your financial responsibilities and meet your daily needs? _____

_____

Family of Origin
Where were you born? _____Where were you raised? _____
Who raised you? _____

Parents' occupation? Mother _____ Father _____

How many siblings do you have? _____ What number are you in the birth order? _____

How would you describe your childhood? _____

Significant Relationships: Current Status:
[ ] Never Married [ ] Married [ ] Living as Married [ ] Widowed
[ ] Separated [ ] Divorced [ ] Partnered [ ] Other _____

Number of times married? _____ Number of times divorced? _____
Spouse/Significant Other/Partner's Name _____ Occupation _____

Length of current relationship? _____

Sexual Orientation: [ ] Heterosexual [ ] Homosexual [ ] Bisexual [ ] Unsure [ ] Other _____
Gender Identity: [ ] Male [ ] Female [ ] Non-Binary [ ] Other _____

Children's Names	**Age**	**Whereabouts**	**Relationship Status**

Do you have a Spiritual Belief/Religious Affiliation? [ ] Yes [ ] No _____

Are there any cultural practices/traditions that you participate in? _____

_____

Please describe your involvement in community activities, social groups, or with friends outside of your home: _____

_____

What types of things do you do for fun? Interests/Activities/Hobbies? _____
_____

Do any of your symptoms impact your ability to socialize with others, engage in the community, or access community resources? If so, please explain: _____

_____

Education

Highest grade completed ____; [ ] Diploma [ ] GED Average grades? _____

Did you attend college? [ ] Yes [ ] No If yes, number of years ____, Area of Study _____

Highest degree earned [ ] Associates [ ] Bachelors [ ] Graduate [ ] Doctorate [ ] other _____

What type of school did you attend? [ ] Home [ ] Public [ ] Private

Have you ever been on an Individualized Education Plan (IEP)? [ ] Yes [ ] No

Were you in special education classes? [ ] Yes [ ] No

Did you have any problems with attention/concentration in school? [ ] Yes [ ] No

Did you have any discipline problems in school? [ ] Yes [ ] No

Employment/Finances

Are you currently employed? [ ] Yes [ ] No Occupation _____

What type of jobs have you had in the past? _____

What's the longest you've ever been at one job? _____

Have you ever been terminated from a job? [ ] Yes [ ] No Explain_____

Have your symptoms ever impeded your ability to work? [ ] yes [ ] no If "yes" please explain: _____

_____

Have you ever been in the Military? [ ] Yes [ ] No

Branch _____ Discharge Status _____

Length of Service _____ Combat Exposure? [ ] Yes [ ] No

Trauma History

Did you experience any childhood trauma (sexual, physical, neglect, accident, loss, illness, etc.)? [ ] Yes [ ] No

Have you experienced any traumatic events as an adult? [ ] Yes [ ] No

Have you ever experienced, engaged in or witnessed domestic violence? [ ] Yes [ ] No

Have you ever been arrested, placed in jail, or prison? [ ] Yes [ ] No

Other

What do you consider to be some of your strengths?

_____

_____

Is there anything else you'd like us to know? _____

_____

_____