Intake Questionnaire

PATIENT INFORMATION		
First Name:	Last Name:	M.I.:
Address:		
City:	State:	Zip:
DOB:	Sex: ☐ Male ☐ Female	
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Spouses Name (if applicable):_____ Children Names (age):_____		
Home Phone:	Cell Phone:	
E-mail Address:		
Work/School Phone:	FAX:	
Employer:	Occupation:	
Employer Address:		

RESPONSIBLE PARTY / SUBSCRIBER OR SPOUSE		
First Name:	Last Name:	M.I.:
Address:		
City:	State:	Zip:
DOB:	Sex: ☐ Male ☐ Female	SS#:
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Home Phone:	Cell Phone:	
E-mail Address:		
Work/School Phone:		
Employer:	Occupation:	
Employer Address:		
Insurance Name:	Policy #:	
Group #:		

PRIMARY PHYSICIAN		
First Name:	Last Name:	
Address:		
City:	State:	Zip:
Phone:	FAX:	
E-mail Address:		

PRIMARY TEACHER (if applicable)		
First Name:	Last Name:	
Address:		
City:	State:	Zip:
Phone:	FAX:	
E-mail Address:		

Referral Source		
First Name:	Last Name:	
Address:		
City:	State:	Zip:
Do we have your permission to release information to the referring professional when it is appropriate?		☐Yes ☐No
Referred by your Insurance Company? Which Insurance Company:_____		☐Yes ☐No
Other Referral Source: _____		

II. Intake Questionnaire

In order for us to be able to fully evaluate you, please fill out the following intake questionnaire to the best of your ability. We realize there is a lot of information and you may not remember or have access to all of it; do the best you can. If there is information you do not want in your medical chart, please note that in the margin. Thank you!

TREATMENT INFORMATION

Purpose of Consultation (Please give a brief summary of the main problems):

Why did you seek treatment at this time?

What services are you interested in? (check all that apply)

☐ Individual Therapy	☐ Adolescent Therapy	☐ Group Therapy
☐ Couples Therapy	☐ Child Therapy	☐ Life Skills Coaching

Prior attempts to correct the problem / Prior Psychiatric/Psychological Treatment
(Please include contact with other professionals, medications, types of treatment, etc.):

Current Life Stresses (include anything that is currently stressful to you, examples include relationships, job, school, finances, children):

What would successful treatment results look like? (What are your treatment goals?):

III. Medical and Family History

MEDICAL HISTORY
Relevant Medical Problems and Conditions (past and current, changes in conditions):
Medications (past and current: dosage, dates if initial prescriptions, length of drug trial, results, name of prescribing MD):
Doctors / Clinics seen regularly:
History of Suicidal or Homicidal thoughts? (past and current, acted on?):
History of Hallucinations?
History of Head Trauma? (describe):
History of Seizures or Seizure-like activity? (Periods of spaciness / confusion / lost time, etc.):
Prior Hospitalizations (place, cause, date, outcome):
Sleep Behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed):

Family History
Family Structure (who lives in your current household):
Current Marital or Relationship Satisfaction:
Significant Developmental Events (include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.):

Legal Custody Arrangement (if patient is a minor):
History of Past Marriages (adult patient and partner / or parents if patient is a minor):
Siblings of minor patient /or children of adult patient (names, ages, problems, strengths):
Cultural / Ethnic & Religious Background:

Natural Mother's History

Age:	Outside work:
School - Highest grade completed:	
Learning problems:	
Behavior problems:	
Marriages:	
Medical Problems:	
Childhood atmosphere (family position, abuse, illnesses, etc.):	
Has mother ever sought psychiatric treatment:	
Mother's alcohol / drug use history:	
Have any of your mother's blood relatives ever had any learning or psychiatric problems including such things as alcohol / drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations (specify):	

Natural Father's History

Age:	Outside work:
School - Highest grade completed:	
Learning problems:	
Behavior problems:	
Marriages:	
Medical Problems:	
Childhood atmosphere (family position, abuse, illnesses, etc.):	
Has father ever sought psychiatric treatment:	
Father's alcohol / drug use history:	

Have any of your father's blood relatives ever had any learning or psychiatric problems including such things as alcohol / drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations (specify):

School History	
Last grade completed:	Last school attended:
Average grades received:	Specific learning disabilities:
Learning strengths:	
Any behavior problems in school:	

Employment History
Summarize jobs you've had, list most favorite and least favorite:
Any work-related problems:
What would your employers or supervisors say about you:
Military history:

Alcohol and Drug History
Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel; what benefit you got from them.). These include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP:
Ever experience withdrawal symptoms from alcohol or drugs:
Has anyone told you they thought you had a problem with drugs or alcohol:
Have you ever felt guilty about your drug or alcohol use:
Have you ever felt annoyed when someone talked to you about your drug or alcohol use:
Have you ever used drugs or alcohol first thing in the morning:
Caffeine use per day (i.e., coffee, tea, sodas, chocolate):

Nicotine use per day, both past and present (i.e., cigarettes, cigars, tobacco chew):
General History
Describe your relationships with friends:
Describe your weaknesses:
Describe your strengths:
Ever had any legal problems:

Availability for Services (Morning, Afternoon, Evenings):

Mon	
Tue	
Wed	
Thur	
Fri	
Sat	
Sun	
Other:	