

# 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:**

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**How long has this been going on?** \_\_\_\_\_

**What made you come in at this time?** \_\_\_\_\_

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**What do you hope to gain from this evaluation and/or counseling?**

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**If you had difficulties in the past, what have you done to cope? Was it helpful?**

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**Symptoms**

Please **check** any symptoms or experiences that you have had **in the last month**

<input type="checkbox"/> Difficulty falling asleep	<input type="checkbox"/> Difficulty staying asleep
<input type="checkbox"/> Difficulty getting out of bed	<input type="checkbox"/> Not feeling rested in the morning
Average hours of sleep per night: _____	
<input type="checkbox"/> Persistent loss of interest in previously enjoyed activities	
<input type="checkbox"/> Withdrawing from other people	<input type="checkbox"/> Spending increased time alone
<input type="checkbox"/> Depressed Mood	<input type="checkbox"/> Feeling Numb
<input type="checkbox"/> Rapid mood changes	<input type="checkbox"/> Irritability
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Panic attacks
<input type="checkbox"/> Frequent feelings of guilt	<input type="checkbox"/> Avoiding people, places, activities or specific things
<input type="checkbox"/> Difficulty leaving your home	
<input type="checkbox"/> Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: _____	
<input type="checkbox"/> Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)	
<input type="checkbox"/> Outbursts of anger	
<input type="checkbox"/> Worthlessness	<input type="checkbox"/> Hopelessness
<input type="checkbox"/> Sadness	<input type="checkbox"/> Helplessness
<input type="checkbox"/> Fear	<input type="checkbox"/> Feeling or acting like a different person
<input type="checkbox"/> Changes in eating/appetite	
<input type="checkbox"/> Eating more	<input type="checkbox"/> Eating less
<input type="checkbox"/> Voluntary vomiting	<input type="checkbox"/> Use of laxatives
<input type="checkbox"/> Excessive exercise to avoid weight gain	<input type="checkbox"/> Binge eating
<input type="checkbox"/> Are you trying to lose weight? _____	
<input type="checkbox"/> Weight gain: _____ lbs	<input type="checkbox"/> Weight loss: _____ lbs.
<input type="checkbox"/> Difficulty catching your breath	<input type="checkbox"/> Increase muscle tension
<input type="checkbox"/> Unusual sweating	<input type="checkbox"/> Easily started, feeling “jumpy”
<input type="checkbox"/> Increased energy	<input type="checkbox"/> Decreased energy
<input type="checkbox"/> Tremor	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Frequent worry	<input type="checkbox"/> Physical sensations others don’t have
<input type="checkbox"/> Racing thoughts	<input type="checkbox"/> Intrusive memories

- Difficulty concentrating or thinking
- Flashbacks
- Thoughts about harming or killing yourself
- 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
- Dependency on others
- Inappropriate expression of anger
- Difficulty or inability to say "no" to others
- Sense of lack of control
- Abusive relationship
- Concerns about your sexuality
- Large gaps in memory
- Nightmares
- Thoughts about harming or killing someone else
- Difficulty meeting role expectations
- Manipulation of others to fulfill your own desires
- Self-mutilation/cutting
- Ineffective communication
- Decreased ability to handle stress
- Difficulty expression emotions

**Sexual Orientation:**  Heterosexual  Homosexual  Bisexual  I choose not to answer

**Please describe any other symptoms or experiences you have had problems with:**

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**Have you seen a counselor, psychologist, psychiatrist or other mental health professional before?**

No  Yes If so:

Name of therapist: \_\_\_\_\_  
Reason for seeking help: \_\_\_\_\_

Dates of Treatment  
\_\_\_\_\_

Name of therapist: \_\_\_\_\_  
Reason for seeking help: \_\_\_\_\_

Dates of Treatment  
\_\_\_\_\_

Name of therapist: \_\_\_\_\_  
Reason for seeking help: \_\_\_\_\_

Dates of Treatment  
\_\_\_\_\_

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:

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**MEDICAL HISTORY**

Are you **CURRENTLY** under treatment for any medical condition?  No  Yes If YES, describe:

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List any **PRIOR** illnesses, operations and accidents

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**FAMILY HISTORY**

**Father:** Age:  Living  
 If deceased, HIS age at time of his death \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Frequency of contact with him: \_\_\_\_\_

Deceased Cause of death: \_\_\_\_\_  
 YOUR age at time of his death \_\_\_\_\_  
 Health: \_\_\_\_\_  
 Are you/Have you been close to him? \_\_\_\_\_

**Mother:** Age:  Living  
 If deceased, HER age at time of his death \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Frequency of contact with him: \_\_\_\_\_

Deceased Cause of death: \_\_\_\_\_  
 YOUR age at time of his death \_\_\_\_\_  
 Health: \_\_\_\_\_  
 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
				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
<b>Nervous Problems</b>							
<b>Depression</b>							
<b>Hyperactivity</b>							
<b>Counseling</b>							
<b>Psychiatric Medication</b>							
<b>Psychiatric Hospitalization</b>							
<b>Suicide Attempt</b>							
<b>Death by Suicide</b>							
<b>Drinking Problem</b>							

**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? \_\_\_\_\_ 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

<b>Drug</b>	<b>Ever Used?</b>	<b>Age at 1<sup>st</sup> use</b>	<b>Time Since Last Use</b>	<b>Approx use in last 30 days</b>
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: \_\_\_\_\_**