Patient Intake Questionnaire

General: **Date:**

Name (Last, Middle Initial, First):

_____

Street Address: _____ City: _____ State: _____

Home phone: _____ Alternate phone:_____

E-mail: _____

Alternate E-mail: _____

Please indicate the means by which you prefer to be contacted. You may check more than one: Phone: _____ Text: ____ E-mail: _____ Regular Mail: ____. If you would prefer to be contacted at a phone number, e-mail, or address other than what is listed above, please provide that information here:

_____

_____

Date of Birth: _____ Age: _____

Gender:

Woman: ___ Man: ___ Transgender: ___ Transman: ___ Transwoman: ___ Gender Nonconforming: ___ Other:

_____

Orientation:

Straight: ___ Gay: ___ Lesbian: ___ Bisexual: ___ Asexual: ___ Queer: ___ Questioning: ___ Other: _____

Prefer not to answer: ___

What type of services are you currently seeking? Please mark an "X" by the type of services you are seeking.

Individual Therapy

Marital/Couples therapy

Family therapy

Group Therapy

Other (describe)

Unsure

Goals of Treatment:

What compelled you to seek therapy at this time?

_____
_____
_____
_____

Describe your current concerns, issues, or problems that you hope to resolve:

_____
_____
_____
_____
_____
_____

What do you hope to gain from therapy?

_____
_____
_____
_____
_____
_____

Relationship Status (Please check all that apply):

Single_____ Engaged _____ Married _____ Seperated _____
Divorced _____ Single Parent_____ Widowed _____

Current Employment Status (Please check all that apply):
Working Full-Time: _____ Working Part-Time: _____ Retired: _____ On medical leave: _____Unemployed and looking for work: _____Not employed due to other reasons ____Full-Time Student: _____ Part-Time Student: _____

Education Information: (Please check the highest level of education/degree you have received):
Elementary, Grades 1-8: _____ Some High School (no diploma): _____ High School Diploma/GED: _____Some College (no degree): _____ Technical/Trade School Graduate: _____Associate's Degree: _____ Bachelor's Degree: _____ Master's Degree: _____ Professional Graduate Degree (i.e., MD, JD, etc.):_____ Doctoral Degree (i.e., PhD, EdD, etc.):_____

Previous Mental Health Treatment History:

Have you participated in therapy? Yes: _____ No: ____

Provide the name of the providers who treated you below. Please indicate the type of provider (i.e., Psychiatrist, Psychologist, MD, or Licensed Therapist).

Name: _____

Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):_____ Phone Number: _____Email _____

Street Address: _____

City: _____ State: _____

Dates of treatment: _____

Name: _____

Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):_____

Phone Number: _____Email _____

Street Address: _____

City: _____ State: _____

Dates of treatment: _____

Name: _____

Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):_____

Phone Number: _____Email _____

Street Address: _____

City: _____ State: _____

Dates of treatment: _____

If you are currently under the care of a psychiatrist, are you taking any prescribed psychiatric medication(s), yes or no? Yes _____ No_____. If you indicated that you are currently taking psychiatric medication, please list the type of medication, the specific medication you have been prescribed, the dosage, and any side effects in the space below.

For example: “Antidepressant (type), Zoloft (specific medication), 50mg once daily (dose), Insomnia (side effect).”_____

_____

_____

_____

_____

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_____

_____

_____

_____

If you are currently under the care of a psychologist, have you participated in any psychological assessments or tests yes, or no? Yes ____ No _____.

If you have participated in psychological testing, please list the type of test performed, the specific name of the test, and the date(s) the test(s) were administered. For example: “Personality Test (Type), Minnesota Multiphasic Personality Inventory “MMPI-2” (Specific name of test), February 01, 2017 (Date test was administered).”

_____
_____
_____
_____
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_____
_____
_____

Medical Treatment Information: Are you currently seeking treatment for a serious or chronic non-psychiatric medical condition, yes or no?

Yes: _____ No: _____.

If you currently have a medical condition, please provide the following information: Current medical condition:

_____

How long have you had the condition?

_____

Is it a medically treatable condition, yes or no?

Yes: _____ No: _____

If, it is not a medically treatable condition (i.e., palliative care), please describe:

_____
_____
_____

_____
_____
_____

If you are currently taking prescribed medications for the condition please describe the type of medication, indicate how long you have been taking the medication, and any side effects. For example: “High blood pressure medication (type of medication); 2 years (length of time on medication); Drowsiness (example of a side effect).

_____
_____
_____
_____
_____
_____
_____

Trauma History (Optional):
Have you been – or are you currently being – emotionally, physically, or sexually abused? Yes _____ No _____ Prefer not to answer _____. If you checked “Yes,” you may use the space below to describe the underlying circumstances:

_____
_____
_____
_____
_____
_____
_____

Family of Origin Information (Optional):
Were you adopted, yes or no? Yes: _____ No: _____. If you were adopted, at what age were you adopted? _____
f you were adopted, do you have a relationship with your birth mother and/or father, yes or no? Yes: _____ No: _____If yes, please describe the nature of the relationship. For example, explain how the relationship with

your biological parent(s) was established, how old you were at the time the relationship began, the frequency of contact you had or currently have, and the nature of the relationship:

_____
_____
_____
_____
_____
_____
_____
_____

If you were adopted, what type of relationship do you/did you have with your adopted parents?

_____
_____
_____
_____
_____
_____
_____

If you were not adopted, what type of relationship do you/did you have with your biological parents?

_____
_____
_____
_____
_____
_____

Please provide the following information about your parents either (biological/adopted) or stepparent:

Name of Mother: _____
Name of Father: _____

Mother's occupation: _____
Father's Occupation: _____
Name of Stepmother: _____
Name of Stepfather: _____
Stepmother's Occupation: _____

Stepfather's Occupation: _____

Are either of your parents (biological or adopted, and/or step parents) deceased? If your parents are deceased, please provide the following information:

- Mother/Stepmother has been deceased for _____ days/weeks/months/years.
  What was your age at the time of your mother's/stepmother's passing? _____
- Father/Stepfather has been deceased for _____ days/weeks/months/years years.
  What was your age at the time of your father's/stepfather's death? _____

Indicate the marital status of your parents (biological/adopted). Check all that may apply:

- Currently married to each other for _____ years
- Currently separated for _____ years
- Divorced for _____years
- Mother remarried _____ times
- Father remarried _____ times
- Mother currently single after being separated/divorced for _____ years
- Father currently single after being separated/divorced for _____ years
- Mother is currently involved with someone, yes or no? If yes, for how long? _____
- Father is currently involved with someone, yes or no? If yes, for how long? _____

Do you have any biological siblings, adopted siblings, step siblings, or half siblings, yes or no? Yes: ____ No: ____. If you have any siblings, how many? _____.

In the space provided below, list the name and ages of each of your siblings and briefly describe the nature of your relationship as being "close," or "not close," or "estranged," or any other word that describes the nature and extent of your relationship with your siblings.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Which of the following statements most resonates with you:

- My parents were present during my *entire* childhood, yes or no?

Yes: _____No: _____.
Explain:_____
_____
_____
_____
_____
_____

- My parents were present during a *part* of my childhood, yes or no?

Yes:_____No_____.
Explain:_____
_____
_____
_____
_____

- My parents were not present at all during my childhood, yes or no? Yes: _____ No: _____. Explain:

_____
_____

_____
_____
_____

Which of the following describes your childhood family experience:
- _____ It was an outstanding home environment
- _____ It was a normal home environment
- _____ It was a chaotic home environment
- _____ Prefer not to answer

If you indicated that your home environment was chaotic, please explain. For example, you may have witnessed physical/verbal/sexual abuse towards others, or you may have experienced physical/verbal/sexual abuse from others:

_____
_____
_____
_____
_____
_____
_____
_____

Mental Health/Risk Assessment:

Please identify if you have experienced any of the following and whether this is a past, current, or reoccurring issue:

•_____ Suicidal Thoughts.

Past:_____ Present: _____ Reoccurring: _____

•_____Thoughts of wanting to intentionally harm myself.

Past:_____ Present: _____ Reoccurring: _____

•_____ Thoughts of wanting to intentionally cause harm to someone else.

Past:_____ Present: _____ Reoccurring: _____

•_____ Post-Traumatic Stress. oPast:_____ Present: _____ Reoccurring: _____

If you are currently experiencing any thoughts of either harming yourself or someone else please answer the following questions:
How long have you had these thoughts?
_____
_____
How frequently do you have these thoughts?
_____
_____
_____
_____
Do you have a plan and/or the means to carry out either the threat of harm to yourself or to someone else, yes or no? Yes: _____ No: _____
If yes, please explain:
_____
_____
_____
_____
Have you ever tried to harm yourself or anyone else in the past, yes or no? Yes: ____ No: ____
If yes, please explain:
_____
_____
_____
_____

Is there anything that would stop, or prevent, you from harming yourself or someone else, yes or no? Yes: ____ No: ____ If yes, please explain?
_____
_____
_____
_____

If you indicated that there is not anything that would prevent you from harming yourself or someone else, please identify how likely it is that you might actually harm yourself or someone else:

Imminently likely: _____ OR Not at all likely: _____

Alcohol/Substance Use History (Optional):

Family Alcohol Abuse History:

To the best of your knowledge, please indicate which of the following family member(s) struggles or struggled with alcohol/substance abuse or addiction:

Father: ___ Mother: ____ Grandparent(s): ____ Sibling(s): _____ Stepparent(s): _____ Uncle(s)/Aunt(s):____ Spouse/SignificantOther:_____ Children: _____

Please indicate your substance use status:

No history of use: _____ Actively using alcohol or drugs: ____ In early full remission: ____ In early partial remission: _____In sustained full remission: _____ In sustained partial remission: _____

If you indicated that you have an alcohol/substance abuse or addiction history, please identify the types of treatment you have participated in, or are currently participating in, and how long you have been participating in the particular treatment.

Outpatient treatment:

_____
_____

Inpatient treatment:

_____
_____

12-Step Program:

_____
_____

Stopped using on my own:

_____
_____

Other Method:

_____
_____

Was the above treatment method effective? Please explain:

_____
_____
_____

Please identify the type(s) of substances you are using, how frequently you use the substance, and how long you have been using the substance, and your frequency of use (i.e., daily, as needed, no regulation of use, etc.)

Opioid(s): ____ Classification: ____ Length of use: _____ Frequency of use: _____
Heroin: ____ Length of use: _____ Frequency of use: _____
Cigarettes/Tobacco: ___ Length of use: _____ Frequency of use: _____
Alcohol: ____ Length of use: _____ Frequency of use: _____
Amphetamines: ____ Length of use: _____Frequency of use: _____
Barbiturates: ____Length of use: _____ Frequency of use: _____
Cocaine: ___ Length of use: _____ Frequency of use: _____
Crack: _____ Length of use: ___ Frequency of use: _____
Hallucinogens: _____ Length of use: ____ Frequency of use: _____
_Inhalants: _____ Length of use: ____Frequency of use: _____
Marijuana: _____ Length of use: ____ Frequency of use: _____
_Other: _____ Length of use: ____ Frequency of use: _____

If you have indicated that you have used, or are currently using substances, please indicate what side effects and or consequences you experienced or are experiencing as a result of the use.

Overdose: _____ Suicidal Impulse: _____ Depression: _____ Anxiety: _____Blackouts: _____ Loss of control: _____ Medical conditions: _____Other: _____

Please use the space provided to describe any other effects or consequences you have experienced:

_____
_____
_____
_____

Spiritual/Cultural History (Optional):

Do you identify with a particular religion, culture, or spiritual practice? If so, please describe:

_____
_____
_____
_____

Do any of the above religious, cultural, or spiritual issues contribute to your current concerns, problems, or issues? If so, please describe:

_____
_____
_____
_____

<u>Additional Information</u>

Please let me know in the space provided, of anything that was not addressed in this intake, and anything that you would like me to know about you, your goals, your relationships, or any recent significant life events:

_____
_____
_____
_____

Patient Signature: _____
Date: _____