ADULT INTAKE QUESTIONAIRE

Please answer the questions as thoroughly as possible.

DATE_____

NAME_____ DOB_____

AGE_____ MARITAL STATUS_____

Current Primary Care Physician (PCP): _____

PCP Phone: _____ Fax: _____

Current Psychiatrist (if applicable):_____

Phone:_____ Fax:_____ _____

Reason for seeing this doctor:

Other health care provider currently involved with your care:

Name:_____

Phone:_____ Fax: _____ _____

Reason child seen by this provider:

Please summarize in 3-5 sentences your main concerns at this time:

HAVE YOU EVER BEEN MARRIED? Y N IF SO, PLEASE DESCRIBE THE NUMBER AND DURATIONS OF EACH_____

DO YOU HAVE ANY CHILDREN? PLEASE LIST THEIR AGES AND WITH WHOM THEY LIVE.

PLEASE LIST THE HIGHEST LEVEL OF SCHOOL YOU HAVE COMPLETED._____

CURRENT AND PAST
EMPLOYMENT_____

HAVE YOU EVER HAD WORKED WITH A MENTAL HEALTH PROVIDER IN THE PAST? Y N

NAMES AND DATES_____

Please check any areas that may be stressful for you now or within the last 6 months:

__ Work situation __ Dating relationship __ Marital relationship

__ Financial difficulty __ Family medical illness __ Parenting

__ Relocation/family move __ Death of loved one __ Divorce

__ Parents/siblings Other _____ Other _____

Describe current and past drug use_____

Describe current and past alcohol use_____

Have you ever tried to harm yourself ? Y N If so, please describe the incident, stressors which may have contributed to the incident, and when the incident occurred:_____ _____

_____

Have you ever been sexually abused? Y N

Have you ever been physically abused? Y N

Have you ever been emotionally abused? Y N

Have you ever had basic needs neglected? Y N

MEDICAL HISTORY

ARE YOU BEING TREATED FOR ANY MEDICAL CONDITION? YES NO IF YES, PLEASE PROVIDE DIAGNOIS,MEDICATIONS AND TREATING HEALYH CARE PROVIDER._____

_____

PRIOR HOSPITALIZATIONS (PLEASE LIS T PLACE, DATE, REASON, OUTCOME):_____

_____

_____

Past Medical History:

Please indicate if you have ever had problems with the following medical conditions.

___Chronic pain___Allergies___ Tics___Auto immune

___Asthma ___Glaucoma ___Heart Problems ___Seizures

___Cancer ___Head Aches ___Kidney Problems ___Thyroid Problems

___Diabetes ___Head Trauma ___Liver Problems ___Memory problems

Please describe the severity and time course for any of these conditions and describe any other medical conditions which were not listed above:_____
_____ _____

_____
_____ _____

Current medications and supplements_____

SLEEP DIFFICULTY FALLING ASLEEP_____ DIFFICULTY STAYING ASLEEP_____

HOURS OF SLEEP_____ WAKEUP RESTED_____

Exercise (Frequency and type)_____

_____

Family History Please *check* if anyone in your family (including extended family) has had a history of:

	NO	YES	Mother	Father
Learning Disability				
Attention Deficit Hyperactivity Disorder (ADHD or ADD)				
Mental Retardation				
Tic Disorder or Tourette's Disorder				
Autism or Developmental Disability				
Anxiety (e.g. Panic Attacks, Generalized Anxiety)				
Obsessive Compulsive Disorder				
Major Depression				
Bipolar Depression				
Suicide (attempts and/or completions)				
Schizophrenia				
Psychiatric Hospitalization				
Severe behavior problems or criminal activities				
Chronic medical illness (please list) Examples: asthma, migraines, fibromyalgia, IBD				
Thyroid disease				
Seizures				
Cancer				
Heart Disease				
Autoimmune Disorders				
Alcohol or chemical dependency				
Other:				

Spiritual Orientation

Please list your spiritual orientation or religion:_____

How active are these beliefs in your life?

Very active **Somewhat active** **Not very active**

Additional comments or concerns:

_____

_____

_____

_____

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