



Intake Questionnaire For New Patients

This questionnaire will help us get to know you better and provide the best possible mental health services.

Please complete this form as honestly and completely as possible.

All information you provide us will be confidential as state and federal law requires.

Date: _____

Social Security Number: _____

Name: _____

Date of Birth: _____ **Age:** _____

Home Address: _____

City/State/Zipcode: _____

Home Phone: _____

Cellular/Alternate Phone: _____

Marital Status: single married separated divorced widowed

In your own words, describe the current problems as you see them:

How long has this been going on?

What made you come in at this time?

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

What have you done to cope if you had difficulties in the past? Was it helpful?

Initials: _____ **DOB:** _____

Symptoms

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

- | | |
|--|---|
| ☐ Withdrawing from other people | ☐ Panic attacks |
| ☐ Spending increased time alone | ☐ Frequent feelings of guilt |
| ☐ Depressed mood | ☐ Sense of lack of control |
| ☐ Feeling numb | ☐ Abusive relationship |
| ☐ Rapid mood changes | ☐ Anger or irritability |
| ☐ Irritability | ☐ Changes in eating/appetite |
| ☐ Anxiety | ☐ Decreased energy |
| ☐ Flashbacks | |
| ☐ Difficulty falling asleep, staying asleep, or waking early in the morning | |
| ☐ Avoiding people, places, activities, or specific things | |
| ☐ Difficulty concentrating or thinking | |
| ☐ Thoughts about harming or killing yourself | |
| ☐ Persistent, repetitive, intrusive thoughts, impulses, or images | |
| ☐ Unusual visual experiences such as flashes of light or shadows | |
| ☐ Hear voices when no one else is present | |
| ☐ Self-mutilation/cutting | |

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

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

☐ No ☐ Yes If so, please list the name and profession: _____

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?

Initials: _____ **DOB:** _____

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:

Any past suicidal thoughts and/or ideas? ☐ No ☐ Yes If YES, describe:

MEDICAL HISTORY

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

List any **PRIOR** illnesses, surgeries, and/or accidents

List any drug allergies:

Initials: _____ DOB: _____

FAMILY

Please place a checkmark in the appropriate box if these are or have been present in your relatives:

	Children	Brothers	Sisters	Father	Mother	Uncle/Aunt	Grandparents
Nervous Problems							
Depression							
Hyperactivity							
Counseling							
Psychiatric Medication							
Psychiatric Hospitalization							
Suicide Attempt							
Death by Suicide							
Alcohol Abuse/Misuse							
Drug Use							

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? _____

Have you ever been abused?

☐ Verbally ☐ Emotionally ☐ Physically ☐ Sexually ☐ Neglected

Please describe: _____

Initials: _____ DOB: _____

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

Drug	Ever Used?	Age at 1st use	Time Since Last Use	Approx use in last 30 days
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				

Is there anything else you would like us to know about you? _____

Initials: _____ **DOB:** _____