# Intake Questionnaire For New Patients

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

**Name**: _____ **Age**: _____

**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:**

_____
_____
_____
_____
_____

**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?**

_____
_____

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

**Symptoms**

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

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Difficulty getting out of bed
- ☐ Not feeling rested in the morning

Average hours of sleep per night: _____

- ☐ Persistent loss of interest in previously enjoyed activities
- ☐ Withdrawing from other people
- ☐ Spending increased time alone
- ☐ Depressed Mood
- ☐ Feeling Numb
- ☐ Rapid mood changes
- ☐ Irritability
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Frequent feelings of guilt
- ☐ Avoiding people, places, activities or specific things
- ☐ Difficulty leaving your home
- ☐ Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: _____
- ☐ Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)
- ☐ Outbursts of anger

- ☐ Worthlessness
- ☐ Hopelessness
- ☐ Sadness
- ☐ Helplessness
- ☐ Fear
- ☐ Feeling or acting like a different person

- ☐ Changes in eating/appetite
- ☐ Eating more
- ☐ Eating less
- ☐ Voluntary vomiting
- ☐ Use of laxatives
- ☐ Excessive exercise to avoid weight gain
- ☐ Binge eating
- ☐ Are you trying to lose weight? _____
- ☐ Weight gain: _____ lbs
- ☐ Weight loss: _____ lbs.

- ☐ Difficulty catching your breath
- ☐ Increase muscle tension
- ☐ Unusual sweating
- ☐ Easily started, feeling "jumpy"
- ☐ Increased energy
- ☐ Decreased energy
- ☐ Tremor
- ☐ Dizziness
- ☐ Frequent worry
- ☐ Physical sensations others don't have
- ☐ Racing thoughts
- ☐ Intrusive memories

- ☐ Difficulty concentrating or thinking
- ☐ Large gaps in memory
- ☐ Flashbacks
- ☐ Nightmares
- ☐ Thoughts about harming or killing yourself
- ☐ Thoughts about harming or killing someone else

- ☐ 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
- [ ] 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
[ ] Other: _____

**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:

Name of therapist: _____ Dates of Treatment
Reason for seeking help: _____ _____

Name of therapist: _____ Dates of Treatment
Reason for seeking help: _____ _____

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:

**Have you ever had homicidal thoughts or violence towards other people?** ☐ No ☐ Yes
If YES, describe:

**Do you have any firearms in your home?** ☐ No ☐ Yes
If YES, are they properly secured? ☐ No ☐ Yes

## MEDICAL HISTORY

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

**List any PRIOR illnesses, operations, accidents, and concussions / head injuries**

## FAMILY HISTORY

***Father:*** Age: ☐ Living ☐ Deceased Cause of death:
If deceased, HIS age at time of his death____ YOUR age at time of his death_____
Occupation: _____ Health: _____
Frequency of contact with him: _____ Are you/Have you been close to him? _____

***Mother:*** Age: ☐ Living ☐ Deceased Cause of death:
If deceased, HER age at time of his death___ YOUR age at time of his death_____
Occupation: _____ Health: _____
Frequency of contact with her: _____ 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 |

**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 |
|---|---|---|---|---|---|---|---|
| **Nervous Problems** | | | | | | | |
| **Depression** | | | | | | | |
| **Hyperactivity** | | | | | | | |
| **Counseling** | | | | | | | |
| **Psychiatric Medication** | | | | | | | |
| **Psychiatric Hospitalization** | | | | | | | |
| **Suicide Attempt** | | | | | | | |
| **Death by Suicide** | | | | | | | |
| **Drinking Problem** | | | | | | | |

## 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 |
|---|---|---|
| | | |
| | | |
| | | |

Do you have a history of prior arrests and /or or legal problems? _____

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

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

***Duty to Warn***

In the event that the undersigned therapist reasonably believes that I am a danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel.

**NAME** **RELATIONSHIP** **TELEPHONE NUMBER**

_____

_____

_____

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

_____

_____

Signature of Client _____ Date _____

Signature of Parent, Legal Guardian, or Power of Attorney _____ Date _____

# 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: _____**

*updated 5/1/23*