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: _____

Name: _____ *Preferred Name (if any):* _____

Age: _____

Are you spiritual or religious? Yes No

Please describe your faith or belief: _____

Sexual Orientation: Heterosexual Homosexual Bisexual I choose not to answer

***(Optional)* Gender Identity:** _____

Preferred Pronouns: _____

Highest Grade Level Completed: _____

Marital Status: Single Married Separated Divorced
Remarried Engaged Widowed Cohabitating

If applicable, please complete the following:

Partner's Name: _____ Partner's Age: _____

Partner's Occupation: _____

Length of Relationship: _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), rate your relationship: _____

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?

_____

_____

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

	Children	Brother(s)	Sister(s)	Father	Mother	Aunt/Uncle	Grandparents
Anxiety							
Depression							
Hyperactivity							
Counseling							
Psychiatric Hospitalization							
Suicide Attempt							
Death by Suicide							
Alcohol/Substance Abuse							
Domestic Violence							
Eating Disorder							
Obsessive Compulsive Behavior							

During your childhood, did you live any significant period of time with anyone other than your biological parents?

- ☐ Yes
- ☐ No

If yes, person's name and relationship to you: _____

Have you ever been abused?

- ☐ No
- ☐ Verbally
- ☐ Emotionally
- ☐ Physically
- ☐ Sexually
- ☐ Neglected

Age(s) of abuse: _____

Relationship to abuser: _____

Please describe: _____

_____

If you are *CURRENTLY* taking any PSYCHIATRIC medications, please list them:

Medication	Dosage	How long have you been taking it?	Has it been helpful?

How many times a week do you exercise or do any physical activities? _____

Please describe: _____

How would you rate your current *mental* health?

Poor Unsatisfactory Satisfactory Good Very good

How would you rate your current *overall* health?

Poor Unsatisfactory Satisfactory Good Very good

Who do you turn to for help with your problems?

_____

Have you ever been arrested? Yes No

If **yes**, please explain: _____

What do you consider to be some of your weaknesses? _____

_____

What do you consider to be some of your strengths? _____

_____

What would you like to accomplish in your time in therapy? _____

_____

If you had difficulties in the past, what coping strategies did you use? Were they helpful?

_____

_____

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

- ☐ Yes
- ☐ No

If **yes**, please provide name of therapist and dates of treatment:

_____

_____

Client's Signature

Symptoms:

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

- ☐ Difficulty falling asleep
- ☐ Difficulty getting out of bed
- ☐ Difficulty staying asleep
- ☐ Nightmares
- ☐ Loss of interest in previously enjoyed activities
- ☐ Withdrawing from other people
- ☐ Depressed Mood
- ☐ Rapid Mood Changes **Explain:** _____
- ☐ Anxiety
- ☐ Frequent feelings of guilt
- ☐ Difficulty Leaving your home
- ☐ Irritability
- ☐ Phobias **Explain:** _____
- ☐ Spending increased time alone
- ☐ Avoiding people, places, activities or specific things
- ☐ Outbursts of anger
- ☐ Changes or difficulties with eating/appetite **Explain:**_____
- ☐ Racing thoughts
- ☐ Intrusive thoughts/memories
- ☐ Increased energy
- ☐ Decreased energy
- ☐ Difficulty concentrating or thinking
- ☐ Thoughts of harming or killing yourself
- ☐ Thoughts about harming or killing someone else
- ☐ Sense of lack of control **Explain:** _____
- ☐ Abusive relationship **Explain:** _____
- ☐ Concerns about your sexuality
- ☐ Difficulty expressing and/or handling emotions
- ☐ Recreational drug use
- ☐ Difficulty/problems at work **Explain:** _____

Please explain any other symptoms or experiences that you have struggled with:

_____

_____

_____

_____