Patient Questionnaire/Intake

Name _____ Date_____

Address _____ Home phone _____

Cell phone _____

E-mail _____ Referred by _____

Age _____ Date of birth _____

Marital status _____ Educational level _____

Occupation _____ Names and ages of children_____

_____

Emergency contact information _____

Explanation of how patient may be contacted by therapist _____

_____

Areas of Concern

What issues/concerns causes you to seek treatment? Please describe. _____

_____

_____

_____

Do you have any specific goals with regard to your treatment? _____

_____

_____

Do you have any particular concerns/fears with regard to treatment? _____

_____

_____

Psychological History:

Have you ever received mental health treatment before? _____

When and for how long? _____

What was the focus of treatment? _____

Name of treating therapist(s) telephone number(s) _____

_____

Inform patient that authorization for release of confidential information will be needed so that any former therapist may be contacted.

Have you ever been subjected to one or more psychological tests? _____

If so, by whom? _____

Name of person(s) administered psychological tests, address(es), telephone number(s)

_____

_____

Inform patient that authorization for release of confidential information will be needed so that any test administrator may be contacted.

Have you ever been hospitalized for mental or emotional problems? _____

When and for how long? _____

Why were you hospitalized? _____

Name of treating therapist, address, telephone number _____

Inform patient that authorization for release of confidential information will be needed so that any former therapists may be contacted.

Are you currently taking any prescription medications? _____

Prescribed by whom? _____

How long have you been on the medications? _____

Have you ever taken any medications for a mental or emotional condition? _____

When and for how long? _____

Inform patient that authorization for release of confidential information will be needed so that health care provider may be contacted.

Have you ever attempted suicide? _____

When? _____

Describe the circumstances that led to that attempt. _____

_____

_____

Are you currently having any suicidal thoughts? Please describe _____

_____

_____

Please describe your childhood. _____

Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe.

_____

_____

_____

Have you ever been a victim of a violent crime? Please describe _____

_____

_____

Medical History

Have you ever been diagnosed with a serious illness? Please describe _____

_____

_____

Do you have any medical conditions that may affect your mental health treatment? _____

Please describe your overall health today. _____

_____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe. _____

_____

_____

Have you ever been in a 12-step program? Please describe. _____

_____

Do you smoke? _____ How much? _____ For how long? _____

Do you drink alcohol? _____

On average, how much alcohol do you consume in a week?_____

Do you currently use illegal drugs? Please describe your use _____

_____

Have you ever used illegal drugs? Please describe. _____

_____

Family of Origin History

Mother's name, age, living/deceased, patient's age at the time of mother's death, description of relationship with mother. _____

_____

_____

Father's name, age, living/deceased, patient's age at the time of father's death, description of relationship with father. _____

_____

_____

Names and ages of siblings. _____

_____

Other Information

Please describe your spiritual identity/orientation. _____

Please describe your interests/hobbies _____

Are you now or have you ever been involved in a lawsuit? _____

Please describe. _____

_____

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested. _____

_____

_____