INTAKE QUESTIONNAIRE
FOR ADULTS, ADOLESCENTS AND CHILDREN

PATIENT INFORMATION

Name: _____ Birth date: _____

CHIEF COMPLAINT

What is your primary reason for seeking this psychological consultation: _____

_____

_____

_____

HISTORY OF PRESENTING ILLNESS:

When did these symptoms begin? _____

_____

When did family members first note these? _____

Did something occur to precipitate them? _____

Have there been symptom free periods? _____

What has the course of symptoms been? _____

PAST PSYCHIATRIC HISTORY:

When were you (your child) first in treatment? _____

_____

What kind of treatment have you (your child) had?

Individual Psychotherapy? If yes, with whom and when? _____

_____

Group Psychotherapy? If yes, with whom and when? _____

_____

Family/Couples Therapy? If yes, with whom and when? _____

_____

PAST PSYCHIATRIC MEDICATIONS:

Name of Medication	Dose Taken	Why Taken	Who Prescribed	Comments (helpfulness / side effects)

CURRENT PSYCHIATRIC MEDICATIONS:

Name of Medication	Dose Taken	Why Taken	Who Prescribed	Comments (helpfulness / side effects)

Have you or your child (if child is being treated) ever been psychiatrically hospitalized? If yes, when, where, and for what reason?

Name of Facility	When and how long?	Precipitating Factors

Have you or your child (if child is being treated) ever thought of committing suicide? If yes, when was the last time and what was the thought? Did you (your child) have a plan?

Have you or your child (if child is being treated) ever attempted to commit suicide? If yes, when, how and under what circumstances?

Have you or your child (if child is being treated) ever hurt yourself in any way? If yes, do you (your child) still do so and how often?

Do you or your child (if child is being treated) now or have you in the past used any alcohol or drugs? If yes, please specify below.

What?	When did you start?	How much did you use?	Last use?	What did it do for you?

MEDICAL HISTORY:

Current Medical Problems _____

_____

Prior Illness: _____

_____

Medical Hospitalizations _____

_____

Surgeries: _____

_____

Please circle any that the patient has had and include dates as best you can:

Head Injury/Loss of Consciousness
Seizures/convulsions
Other neurological problems
Ear, nose or throat problems
Dental problems
Asthma
Chest problems
Stomach or bowel problems/soiling
Urinary or bladder/wetting
Gynecological/menstrual problems
Others:

Heart Problems
Rheumatic fever/strep infections
Liver/Kidney problems
Skin problems
Joint/limb problems
Hearing/vision problems
Growth/endocrine problems
Serious accidents/fractures
Childhood measles/mumps
Chicken Pox

Immunizations: Up to Date? Y / N

Most Recent Physical Exam: _____

Date: _____ Results: _____

FAMILY HISTORY:

1. Give the names, ages, and relationships of people **living in the home:**

Parent or Spouse Name: _____ Age: _____ Relationship: _____

Parent Name(s): _____ Age: _____ Relationship: _____

Siblings or Children's Name(s): _____ Age: _____ Grade/Occupation: _____

_____ Age: _____ Grade/Occupation: _____

_____ Age: _____ Grade/Occupation: _____

2. Who are other immediate family members not living in the home?_____

_____

_____

FAMILY PSYCHIATRIC HISTORY:
Has any family member had any of the following? Please circle and indicate which family member.

Depression _____ ADHD/ADD _____

Mania/Bipolar Disorder _____ Learning Disability _____

Suicidal thoughts/urges/behaviors _____ Coordination Problems _____

Anxiety _____ Mental Retardation _____

Panic _____ Autism/Asperger's Disorder/PDD _____

Obsessions/Compulsions _____ Sleep Disorder _____

Rituals _____ Drug Use _____

Movement Disorders _____ Alcohol Use _____

Tics _____ Psychosis _____

Unusual noises/vocalizations _____ Legal Problems _____

Eating Disorder _____ Psychiatric Hospitalizations _____

Other: _____

Please elaborate on above as needed: _____

_____

_____

_____

FAMILY MEDICAL HISTORY:
Please provide information about significant medical issues on the FATHER'S side:

_____

_____

_____

_____

Please provide information about significant medical issues on the MOTHER'S side:

_____

_____

_____

_____

PRENATAL HISTORY:
Was the pregnancy healthy? Yes No Problems: _____

Were medications used during the pregnancy? Yes No If yes, what kind? _____

_____

How Often? _____

Were drugs/alcohol used during the pregnancy? Yes ____ No ____

If yes, how much/often? _____

Did the mother smoked during the pregnancy? Yes ____ No ____ If yes how much? _____

Was the pregnancy full term? Yes ___ No ___

Was delivery normal? Yes ___ No ___ If no, problems? _____

Any feeding problems? _____ Gain weight well? _____

Was there any problem in the first week? _____

First month? _____

First year? _____

Total number of pregnancies: ____ Live births: ____ Birth order of this child: _____

DEVELOPMENTAL HISTORY:

1. Describe yourself or child (if child is being treated) as an infant:

   a) active / active but calm / passive / other:

   b) cuddly / irritable / withdrawn / other:

   c) cried easily and frequently / reasonable amount / seldom

   d) soothed easily / difficult to soothe / average

   e) response to changes: severe / moderate / mild

   f) response to being held (describe):

   g) reaction to strangers: friendly / indifferent / fearful

2. Describe your or child's (if child is being treated) eating habits: _____

Problems: _____

3. Describe your or child's (if child is being treated) sleeping habits: _____

Problems: _____

4. Developmental Milestones (only mark if significantly early or late):

MOTOR: LANGUAGE: ADAPTIVE:

rolled front/back (4 mo) _____	smiling (4-6 wks) _____	mouthing (3 mo) _____
sit with support (6 mo) _____	cooing (3 mo) _____	transfers objects (6 mo) _____
sit alone (9-10) _____	babbling (6 mo) _____	picks up raisin (11-12 mo) _____
pull to stand (10 mo) _____	jargon (10-14 mo) _____	scribble (15 mo) _____
crawling (10-12 mo) _____	first word (12 mo) _____	drinks from cup (10 mo) _____
walks alone (10-18 mo) _____	follows 1-step command (15 mo) _____	uses spoon (12-15 mo) _____
running (15-24 mo) _____	2 word combo (22 mo) _____	wash hands _____
tricycle (3 yrs) _____	3 word sentence (3 yrs) _____	undresses _____
bicycle (5-7 yrs) _____	speech problem? Y/N _____	bowel trained _____

SCHOOL:

Name of child's current school or if adult, last school attended: _____

Grade/Major: _____ Repeat Grade? Y/N Which? _____

Special/resource classes Y/N? _____ If yes, what classes? _____

Other special services? (speech/OT) _____

IEP? _____ 504 Plan? _____ Academic grades received: _____

Evaluations performed:

Date _____ Type _____ Reasons _____

Results _____

Date _____ Type _____ Reasons _____

Results _____

Relationships with teachers? _____ With peers? _____

Ability to work independently?	good	average	poor
Organize self?	good	average	poor
Attendance?	good	average	poor

Have you or your child (if child is being treated) ever had truancy proceedings? Y/N

Have you or your child (if child is being treated) had any other legal proceedings? Y/N If Yes, please describe.

_____

_____

Have you or your child (if child is being treated) received counseling at school?

_____

_____

Describe your or your child's (if child is being treated) activities, interests, hobbies, skills, strengths:

_____

_____

_____

_____

OTHER: Please use the remaining space to describe any other concerns or strengths you or your child (if child is being treated) has:

_____

_____

_____

_____

_____

PROBLEM BEHAVIOR CHECKLIST: DO YOU OR YOUR CHILD (IF YOUR CHILD IS BEING TREATED) HAVE ANY OF THE FOLLOWING PROBLEMS?

	In Past	Occasionally	Often	Very Often
Short Attention Span				
Impulsivity (acts before thinking)				
Won't follow rules/directions				
Irritable, poor frustration tolerance				
Easily riled up				
Picks on others, bullies				
Feels picked on				
Teases others unmercifully				
Deliberately tries to annoy people				
Easily angered, bad temper				
Frequent accidents				
Gets out of control				
Gets violent and aggressive				
Cruel to animals				
Fire Setting				
Steals				
Cries easily				
Gets giddy and silly				
Tiredness/listlessness				
Lack of interest in activities				
Isolates self from others				
Sadness				
Poor appetite				
Problems getting to sleep				
Early morning awakening				
Self-injurious/abusive behaviors				
Excessive sleepiness				
Weight gain/loss				
Worries a lot				
Fear of the dark				
Other specific fears (heights, etc)				
Catastrophic fears				
Reluctance to go to school				
Repeated unwanted thoughts				
Compulsive behaviors				
Rituals (has to repeat same action)				
Hair pulling				
Excessive concerns: body defects				