INTAKE QUESTIONNAIRE
FOR ADULTS, ADOLESCENTS AND CHILDREN

PATIENT INFORMATION

Name: ______________________ Date of Birth: ______________

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:

Primary Care Physician ______________________ Phone ______________________

Address ______________________________

Current Medical Problems: ______________________________

____

Prior Illness: ______________________________

____

Medical Hospitalizations: ______________________________

____

Surgeries: ______________________________

____

PLEASE CHECK IF YOU HAVE EVER RECEIVED MEDICAL ATTENTION FOR

☐	ABNORMAL BLEEDING	☐	FEVER	☐	PALPITATIONS
☐	ABDOMINAL SWELLING	☐	FREQUENT AWAKENING TO URINATE	☐	RASH
☐	ANEMIA	☐	HEADACHE	☐	SEIZURES OR BLACKOUT SPELLS
☐	ASTHMA OR WHEEZING	☐	HEART MURMUR	☐	SENSITIVITY - HEAT OR COLD
☐	BACKACHE	☐	HIGH BLOOD PRESSURE	☐	SEXUALLY TRANSMITTED DISEASES
☐	BLEEDING GUMS	☐	HOARSENESS	☐	SHORTNESS OF BREATH
☐	BLOOD IN STOOL	☐	INCOORDINATION	☐	SINUS PROBLEMS
☐	BREAST LUMPS	☐	INCREASE IN URINARY FREQUENCY	☐	SORE THROATS
☐	CALF CRAMPS WHEN WALKING	☐	JAUNDICE	☐	STOMACH PAINS
☐	CHEST PAIN	☐	LIP SORES	☐	SWELLING OF ANKLES / FEET
☐	CONSTIPATION	☐	LOSS OF HEARING	☐	SWELLING, STIFFNESS
☐	COUGH	☐	MIGRAINES	☐	TICS OR TREMOR
☐	DIARRHEA	☐	MUSCLE /JOINT PAIN	☐	ULCER DISEASE
☐	DIFFICULTY STARTING URINE STREAM	☐	MUSCLE WEAKNESS OR PARALYSIS	☐	UNUSUAL APPETITE
		☐	NAUSEA / VOMITING	☐	UNUSUAL THIRST
☐	DIZZINESS	☐	NECK SWELLING	☐	URINARY INFECTIONS
☐	EARACHE	☐	NERVOUS BREAKDOWN	☐	VISUAL PROBLEMS
☐	EASY BRUISING	☐	NIGHT SWEATS	☐	WEIGHT LOSS
☐	EYE IRRITATION	☐	NOSEBLEEDS	☐	WEIGHT LOSS
☐	EYE PAIN	☐	NUMBNESS	☐	

MEDICATION ALLERGIES List here: ____

____

Are you allergic to any: ☐ Environment ☐ Foods ☐ Animals ☐ Household Chemical Products

Have you ever been exposed to any toxic substances or radiation? ☐ Yes ☐ No

DAILY LIVING

Exercise: Do you exercise regularly? Yes No If Yes, Describe: ____________________

Current weight in pounds: ________ Highest past year: ________ Lowest past year: ________ Ideal weight: ________

Height: ______________

Caffeine: Do you drink coffee? ☐ Yes ☐ No Tea? ☐ Yes ☐ No Cola? ☐ Yes ☐ No

Tobacco: Do you smoke? ☐ Yes ☐ No How much daily? ________ When did you start? ____________

Alcohol: Do you drink alcohol? ☐ Yes ☐ No How many drinks daily? ____________________

Please describe any change in your alcohol consumption: ____________________

Street drugs: ☐ Yes ☐ No Please list any you have taken: ____________________

Pets: ☐ Yes ☐ No Please list your pets, If any ____________________

IMMUNIZATIONS (CHECK IF UP TO DATE)

☐ DPT or TD ☐ polio ☐ rubella ☐ measles ☐ mumps ☐ booster ☐ booster

Date of most recent physical exam: ______________ **Results:** ____________________

WOMEN

DATE OF LAST NORMAL MENSTRUAL PERIOD?	ARE YOUR PERIODS REGULAR? ☐ YES ☐ NO	NUMBER OF PREGNANCIES?	NO. OF CHILDREN?	MISCARRIAGES?
ABNORMALITIES WITH MENSTRUATION? ☐ YES ☐ NO	EXCESSIVE BLEEDING? ☐ YES ☐ NO	IRREGULAR BLEEDING? ☐ YES ☐ NO	PAINFUL MENSTRUATION? ☐ YES ☐ NO	
ABNORMAL VAGINAL DISCHARGE? ☐ YES ☐ NO	TYPE OF BIRTH CONTROL?		ABORTIONS?	

MEN

Age of onset of puberty: ________

Do you have any difficulty with sexual functioning? ☐ YES ☐ NO

Do you have any burning or discharge from your penis? ☐ YES ☐ NO

Do you have difficulty with erection? ☐ YES ☐ NO

Do you have swelling or lumps on your testicles? ☐ YES ☐ NO

IF ANY ABOVE ANSWERS ARE YES, GIVE FULL DETAILS

____

____

____

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 indicate which family member.

ADHD ____________

Alcohol Abuse ____________

Anxiety ____________

Autism/ Asperger's Disorder/PDD ____________

Coordination Problems ____________

Depression ____________

Drug Use ____________

Eating Disorder ____________

Learning Disability ____________

Legal Problems ____________

Mania/Bipolar Disorder ____________

Mental Retardation ____________

Movement Disorders ____________

Obsessions/Compulsions ____________

Panic ____________

Psychiatric Hospitalizations ____________

Psychosis ____________

Rituals ____________

Sleep Disorder ____________

Suicidal thoughts/ urges/behaviors ____________

Tics ____________

Unusual noises/ vocalizations ____________

Other: ____________

Please elaborate on above as needed: ____________

____

____

FAMILY MEDICAL HISTORY:

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

____

____

Please provide information about significant medical issues on the BIOLOGICAL 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 smoke 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? Yes No Gain weight well? Yes No

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) response to changes: severe / moderate / mild

   (e) response to being held (describe): ____________

   ____

   (f) reaction to strangers: friendly / indifferent / fearful

   (g) soothed easily / difficult to soothe / average

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:

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: (TO BE FILLED OUT OF PATIENT IS A CHILD/ADOLESCENT OR IN COLLEGE)

Name of child's current school: ________________________ 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 If Yes, please describe.

____

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:

____

____

____

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

	Never	Occasionally	Often	Very Often
Catastrophic fears				
Compulsive behaviors				
Cries easily				
Cruel to animals				
Deliberately annoy people				
Early morning awakening				
Easily angered, bad temper				
Easily riled up				
Excessive concerns (body defects)				
Excessive sleepiness				
Fear of the dark				
Feels picked on				
Fire Setting				
Frequent accidents				
Gets giddy and silly				
Gets out of control				
Gets violent and aggressive				
Hair pulling				
Impulsivity (acts before thinking)				

Never	Occasionally	Often	Very Often	
				Irritable, poor frustration tolerance
				Isolates self from others
				Lack of interest in activities
				Other specific fears (heights, etc)
				Picks on others, bullies
				Poor appetite
				Problems getting to sleep
				Reluctance to go to school
				Repeated unwanted thoughts
				Rituals (has to repeat same action)
				Sadness
				Self-injurious/abusive behaviors
				Short Attention Span
				Steals
				Teases others unmercifully
				Tiredness/listlessness
				Weight gain/loss
				Won't follow rules/directions
				Worries a lot