Adult Intake Questionnaire

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**: _____

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

Home Address:_____ **City/State/Zip code**: _____

Home Phone:_____ **Cellular/Alternate Phone**: _____

Marital Status: Married Widowed Single divorced remarried

In your own words, describe the current problems as you see them/Reason for referral:

_____
_____
_____
_____
_____
_____
_____
_____

How long has this been going on?

_____
_____
_____
_____
_____
_____
_____
_____

What made you come in at this time?

_____
_____
_____
_____

MEDICAL HISTORY

Are you CURRENTLY under treatment for any medical condition? No Yes

If YES, Please provide medical diagnosis:

_____

What medications are you CURRENTLY taking?

List any PRIOR illnesses, operations and accidents?

Mental Health History

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?**

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, please list:

Hospital	Dates	Reason

Have you ever attempted suicide? ☐ No ☐ Yes If YES, describe:

_____

_____

_____

_____

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 per night: _____ ☐ Not feeling rested in the morning Average hours of sleep

☐ 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

☐ Voluntary vomiting ☐ Use of laxatives Excessive exercise to avoid weight gain

☐ ☐ Binge eating Are you trying to lose weight? _____

☐ ☐

☐ Increase muscle tension Weight gain:__lbs ☐ Weight loss:_____lbs.

☐ 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
- ☐ Difficulty meeting role expectations
- ☐ Dependency on others
- ☐ Manipulation of others to fulfill your own desires
- ☐ Inappropriate expression of anger
- ☐ Self-mutilation/cutting Difficulty or inability to say "no" or others
- ☐ Ineffective communication
- ☐ Sense of lack of control
- ☐ Decreased ability to handle stress
- ☐ Abusive relationship
- ☐ Difficulty expression emotions Concerns about your sexuality

Have you ever been abused?

☐ Verbally ☐ Emotionally ☐ Physically ☐ Sexually ☐ Neglected

Please describe:

_____

_____

_____

_____

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							

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 yourdrinking/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 relievea 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				

Have you been arrested? If yes, please describe**:**_____

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

WHO CURRENTLY LIVES IN YOUR RESIDENCE (adults and children):

	Name	Relation	Age	Name	Relation		

IF YOU HAVE CHILDREN PLEASE LIST THEIR NAMES AND AGES:

	Name		Age	Name		

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 him:_____ 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**

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

_____

_____

_____

Do you have a religious affiliation? If so, what: _____

What kind of social activities do you participate in? _____

Who do you turn to for help with your problems? _____

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ I choose not to answer

Please describe any other symptoms or experiences you have had problems with:

_____

_____

_____

_____

Initial Diagnostic Interview (90791)

To be Completed by the Psychologist

Patient Name:_____ Date:_____

Diagnostic Impression (D M-5/ICD-10 Code): Primary Diagnosis/es (check all that apply):

F41.l Gen Anxiety d/o F31.81 Bipolar d/O F22 Delusional d/o

F33.l Major Depressive d/o, rec, mod F43.22 Adjustment d/o w/ anxiety

F43.2 l Adj. d/o w/ depressed mood F43.24 Adj d/o / dist. of conduct

F43.23 Adj. d/o w/ mixed anx. & depress mood

F43.25 Adj d/o w/ mixed dist. of emotions & conduct F43.l 0 Post-traumatic stress d/o

Other DX:_____

Recommendation:

___Emergency Psychiatric Intervention: _____
___ Psychotherapy: _ Continue to Assess _Individual: Verbal / Supportive
___Ongoing assessment of: _ Cognitive Skills _Broad emotional status
_ Degree of Depression __Degree of Anxiety Other:_____
___ Further Psychological Testing is need to assess:_____
___Psychiatric Evaluation for Medication Management
___Family Conference to address:_____
___Behavior Management for (List Behaviors):_____
___Social Work: _____
___Other:_____

Estimate Number of Treatment Sessions Required: _____

Summary/Rationale:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature: _____ Date: _____
Licensed Psychologist