Adult Intake Questionnaires

In order for me to be able to fully evaluate you, please fill out the following intake form and questionnaires to the best of your ability. I realize there is a lot of information and you may not remember or have access to all of it; do the best you can. If there is information you do not want in your medical chart it is ok to refrain from putting it in this information. Thank you!

PATIENT IDENTIFICATION

Name _____ First Appointment Date _____
Birth Date _____ Age _____ Sex _____ Race ____ Marital Status ____
Religion _____ Preferred Pronoun_____
Address _____
City _____ State ____ Zip _____
Home Phone: _____ Work Phone: _____
Cell:_____ Email: _____
Children's Names and ages _____
_____
Who are you currently living with? _____
_____
How were you referred to the Center for Integrative Psychology? Circle One
Internet Search Friend Physician School Psychiatrist Amen Clinic Therapist Other
Name _____
Address _____
Phone: _____ Fax: _____ Email: _____
Do I have your permission to release information to the referring professional when it is appropriate?
Yes ____ No _____

Main Purpose of the consultation (Please give a brief summary of the main problems)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

What happened to make you seek evaluation at this time?

_____

_____

_____

_____

_____

_____

_____

Prior Attempts to correct the problem/Prior psychiatric history:
(Please include contact with other professionals, medications, types of treatment, etc.)

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY

Current medical problems: _____

_____

Past medical problems: _____

_____

Other doctors/clinics seen regularly: _____

Any history of hitting your head, even if you don't lose consciousness? (e.g. car accident, hitting head on monkey bars, playing football, soccer, or boxing etc.):

_____

_____

Have you ever lost consciousness: _____

Have you been exposed to toxic substances? (e.g. furniture refinishing, agent orange, pesticides, etc)

_____

Ever any seizures or seizure like activity? _____

Prior hospitalizations (place, cause, date, outcome): _____

Prior abnormal lab tests, X-rays, EEG, etc: _____

Allergies/drug intolerances (describe): _____

Do you have mold in your house? _____

Do you have a carbon monoxide detector in your house? Yes No

Do you have silver amalgam dental fillings? Yes No

Present Height _____ Present Weight _____

Current Life Stresses: (include anything that is currently stressful for you, examples include relationships, job, school, finances, children)_____
_____
_____
_____

Prenatal and birth events: Your parents' attitudes toward their pregnancy with you _____
Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc_____
Any birth problems, trauma, forceps or complications?_____

Sleep behavior:

Is it hard for you to make yourself go to bed? ☐ ☐ Explain: _____
How long does it take you to fall asleep? _____

Do you stay asleep? ☐ ☐

Do you snore? ☐ ☐

Do you have sleepwalking, nightmares, night terrors, recurrent dreams, restless legs, talking in your sleep:
_____
_____

School History: Last grade completed _____ Last school attended _____
Average grades received _____ Specific learning disabilities _____
Learning strengths _____
Any behavior problems in school? _____
What have teachers said about you?_____
Please bring school report cards and any state, national or special testing that has been performed.

Employment History: (summarize jobs you've had, list most favorite and least favorite)
_____
_____
_____
Any work-related problems? _____
What would your employers or supervisors say about you? _____
_____

Military History? _____
_____

Ever Any Legal Problems? _____
_____

Alcohol and Drug History: (Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel; what benefit you got from them.). These include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms, PCP). _____

Do you or have you ever experience withdrawal symptoms from alcohol or drugs? _____
Has anyone told you they thought you had a problem with drugs or alcohol? _____
Have you ever felt guilty about your drug or alcohol use? _____
Have you ever felt annoyed when someone talked to you about your drug or alcohol use? _____
Have you ever used drugs or alcohol first thing in the morning?_____
Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate) _____
Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew) _____

Sexual history: (answer only as much as you feel comfortable)
Primary Sexual Orientation: Gay, Straight, Bisexual
Age at the time of first sexual experience: _____ Number of sexual partners: _____
Any history of sexually transmitted disease? _____ History of abortion? _____
History of sexual abuse, molestation or rape? _____
Current sexual problems?_____
Any history of being physically or sexually abused? Yes No

FAMILY HISTORY

Family Structure (who lives in your current household, please give relationship to each):

Current Marital or Relationship Satisfaction_____

Significant Life Events (include past and current marriages, separations, divorces, deaths, traumatic events, losses, abuse,
etc.)_____

Natural Mother's History: age_____ occupation _____
School: highest grade completed _____
Learning problems _____
Behavior problems _____
Marriages _____
Medical Problems _____
Childhood atmosphere (family position, abuse, illnesses, etc)_____
Has mother ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____

Mother's alcohol/drug use history

_____

Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

_____

_____

Natural Father's History: age_____ occupation _____

School: highest grade completed _____

Learning problems _____

Behavior problems _____

Marriages _____

Medical Problems _____

Childhood atmosphere (family position, abuse, illnesses, etc) _____

_____

Has father ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____

_____

Father's alcohol/drug use history

_____

Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

_____

_____

Siblings: Name Age relationship to patient Problems Strengths

_____

_____

_____

Children: Name Age relationship to patient Problems Strengths

_____

_____

_____

Cultural/Ethnic Background:

_____

_____

Describe your relationships with friends:

_____

_____

Describe yourself:

_____

_____

Describe your strengths:

What would you like to accomplish in your meeting with staff at the Center for Integrative Psychology?

Primary Care Physician: _____

Address: _____

_____

_____

Phone: _____

Psychiatrist: _____

Address: _____

_____

_____

Phone: _____

List all medications you are taking and their dosage:

_____ prescribed by: _____

_____ prescribed by: _____

_____ prescribed by: _____

_____ prescribed by: _____

_____ prescribed by: _____

List supplements you are taking:

_____

_____

_____

_____

_____

_____

Primary Insurance Information:

Insurance Company name: _____
Policy Number or Contract # _____ Group #: _____
Service Code #: _____
Social Security number of Policyholder: _____
Employer Name: _____
Name of policyholder: _____
Birth Date of policyholder: _____
Address of policyholder: _____
City: _____ State: ____ Zip: _____ Phone: _____

Secondary Insurance Information:
Insurance Company name: _____
Policy Number or Contract # _____ Group #: _____
Service Code #: _____
Social Security number of this policyholder: _____
Employer Name: _____
Name of secondary policyholder: _____
Birth Date of second responsible party: _____
Address of second policyholder: _____
City: _____ State: ____ Zip: _____ Phone: _____

I understand as the primary responsible party, I will pay for all portions of charges that my insurance Company does not cover. I authorize the Center for Integrative Psychology to electronically transmit the claim to the insurance company, send any necessary documentation and discuss this case including diagnosis and other information from the clinical record with the insurance companies listed. I authorize my insurance company to send benefits directly to the Center for Integrative Psychology.

In the case of canceled appointments, I agree to provide **48 hours** notice to the Center for Integrative Psychology or be responsible for a $150 missed appointment fee that is not covered by the insurance company.

Signature of Responsible Party: _____ Date: _____

This is an adaptation from an intake form developed by Daniel Amen, M.D.