CENTER FOR INTEGRATIVE PSYCHOLOGY

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 ______________________________
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?

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____

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

____

____

____

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____

____

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? Yes No Explain: ____
How long does it take you to fall asleep? _______________

Do you stay asleep? Yes No

Do you snore? Yes No

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.