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Intake Questionnaire

Complaint
What is your major complaint? :

Have you previously suffered from this complaint? :

If Yes, enter previous therapist(s) seen for complaint, describe treatment:

Aggravating Factors:

Relieving Factors:

Current Symptoms (check all that apply)

☐Anxiety
☐Appetite Issues
☐Avoidance
☐Crying Spells
☐Depression
☐Suicidal Thoughts
☐Excessive Energy
☐Fatigue
☐Guilt
☐Hallucinations
☐Impulsivity
☐Irritability
☐Libido Changes
☐Loss of Interest
☐Panic Attacks
☐Racing Thoughts

☐ Risky Activity
☐ Sleep Changes
☐ Suspiciousness

Medical History

Exercise Frequency:

Exercise Type:

Allergies:

What medications are you currently using?

Previous diagnoses/mental health treatment:

Previously treated by:

Previous medications:

Dates treated:

Previous medical conditions:

Previous surgeries:

Family History

Were you adopted? If yes, at what age?:

How is your relationship with your mother?:

How is your relationship with your father?:

Siblings and their ages:

Are your parents married?:

Did your parents divorce? If yes, how old were you?:

Did your parents remarry? If yes, how old were you?:

Who raised you? Where did you grow up?:

Family member medical conditions:

Family member mental conditions:

Treated with medication?:

Medications:

Present Situation
Work:

Are you married? If yes, specify date of marriage:

Are you divorced? If yes, specify date of divorce:

Prior marriages? If yes, how many?:

What is your sexual orientation?:

Are you sexually active?:

How is your relationship with your partner?:

Do you have child(ren)? If yes, how is your relationship with your child(ren)?:

Are you a member of a religion/spiritual group?:

Have you ever been arrested? If yes, when and why?:

Have you ever tried the following?
(check all that apply)
☐ Alcohol
☐ Tobacco
☐ Marijuanna
☐ Hallucinogens (LSD)
☐ Heroin
☐ Methamphetamines
☐ Cocaine
☐ Stimulants (Pills)
☐ Ecstasy
☐ Methadone
☐ Tranquilizers
☐ Pain Killers
If yes to any, list frequency/dates of use:

Have you ever been treated for drug/alcohol abuse? If yes, when?:

Do you smoke cigarettes? If yes, how many per day?:

Do you drink caffeinated beverages? If yes, how many per day?:

Have you ever abused prescription drugs? If yes, which ones?:

Additional
Anything else you want me to know?: