

# NEW PATIENT INTAKE QUESTIONNAIRE

(Please complete all information)



Name: \_\_\_\_\_ Initial Appointment Date: \_\_\_\_\_

## PERSONAL

Date of Birth: \_\_\_\_\_

What town do you live in? \_\_\_\_\_

How long have you lived there? \_\_\_\_\_

Where did you grow up? \_\_\_\_\_

Who do you live with? Self Parents children Spouse Other

## SCHOOL

High School Associate Bachelors Masters/PHD Other

Where did you last go to school? \_\_\_\_\_

What did you/are you studying? (If applicable) \_\_\_\_\_

## MARITAL STATUS (check closest answer):

Single Married Divorced/separated Widowed Live with significant other Other (not listed)

### Children(s)

First Name:

Age:

_____	_____
_____	_____
_____	_____
_____	_____

## WORK HISTORY

If currently working:

Employer \_\_\_\_\_

Full time Part time Total hours per week \_\_\_\_\_

If not working Last time employed: \_\_\_\_\_

Type of work: \_\_\_\_\_

## MEDICAL HISTORY

Primary Care Doctor \_\_\_\_\_ When was your last physical \_\_\_\_\_

Other important doctors: \_\_\_\_\_

Important Medical conditions: \_\_\_\_\_

\_\_\_\_\_

Drug allergies: \_\_\_\_\_

Current Medications (not including psychiatric meds):

_____
_____
_____
_____

NEW PATIENT INTAKE QUESTIONNAIRE (CONT.)



**PSYCHIATRIC HISTORY:**

Last psychiatrist Name (if applicable): \_\_\_\_\_

What was the reason you left your last psychiatrist? \_\_\_\_\_

When (if ever) you were first treated for a psychiatric problem: \_\_\_\_\_

What was the problem? \_\_\_\_\_

What diagnoses have you been given (list the ones that you think describes your problem

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have had psychiatric hospitalizations:

When was the first hospitalization: \_\_\_\_\_

How many times have you been hospitalized? \_\_\_\_\_

What were the reasons you were hospitalized? \_\_\_\_\_

Have you ever left a hospital against medical advice?  Yes  No

If yes explain: \_\_\_\_\_

**PSYCHIATRIC MEDICATION HISTORY:**

Medication	Side effects	Effectiveness	Reason stopped*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have thoughts that you would rather be dead? (Put X? on line)

.....|.....|.....|.....|  
None                      rarely                      often                      most of the time

If you have recently thought of killing yourself, how have you thought of doing it?

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_

# NEW PATIENT INTAKE QUESTIONNAIRE (CONT.)



Have you ever tried to kill yourself? Yes No

If yes when and how? \_\_\_\_\_

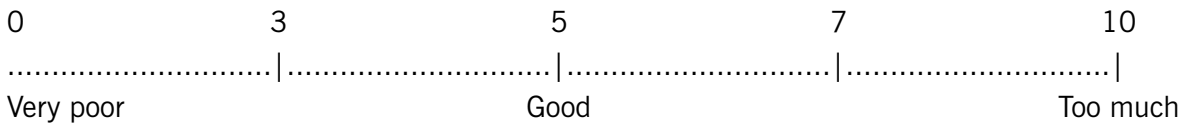
## LEGAL

Current legal concerns: \_\_\_\_\_

Past legal concerns: \_\_\_\_\_

## PAST CONCERNS

Appetite:



Weight gain or loss in the past 3 months \_\_\_\_\_ pounds

Do you have trouble sleeping too much or too little? \_\_\_\_\_

Please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## CURRENT CONCERNS

What is the biggest reason you are seeking help? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are other important concerns? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are the biggest stressors in your life (biggest first)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How much support do you have from family (1-10): \_\_\_\_\_

Who (Mother, spouse, etc)? \_\_\_\_\_

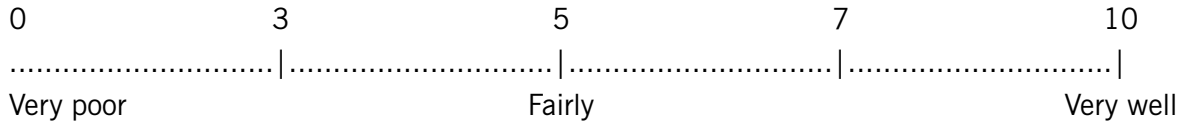
How much other support do you have (1-10)? \_\_\_\_\_

Who (friends, minister, etc): \_\_\_\_\_

NEW PATIENT INTAKE QUESTIONNAIRE (CONT.)

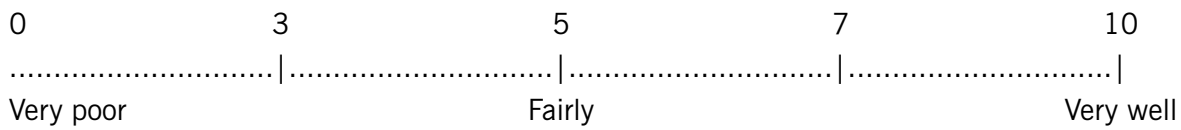


How well are you functioning at home and socially?



Major problem at home & socially: \_\_\_\_\_

How well are you functioning at work or school?



Major problem at work or school: \_\_\_\_\_

What are your goals for treatment (please be as specific as possible)?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_