Adult Intake Questionnaire

BLACK INK ONLY

Patient Name: _____ Date: _____

DOB: _____ Age: _____ Sex: ☐ Male ☐ Female

Marital Status: _____ Ethnicity: _____

Name of Person completing the form: _____

Reason for Visit & Problem you are experiencing: _____

_____

_____

_____

_____

1. I have problems with: Check All That Apply

☐ Sad moods ☐ Not eating ☐ Eating too much ☐ sleeping too much ☐ not sleeping

☐ Experiencing head aches, or stomach aches a lot ☐ No energy or motivation

☐ Wanting to die ☐ Hurting myself ☐Hurting others ☐ feeling guilty a lot

☐ Poor concentration ☐ Feeling hopeless

☐Mood swings ☐ Being distracted ☐Racing thoughts ☐↑Activity ☐Talking a lot

☐ Becoming angry easily ☐Feeling paranoid ☐Hearing voices

☐Seeing things others don't see ☐Worrying excessively about things

☐Having panic attacks ☐ Experiencing flash backs

2. History of behavioral or emotional problems

A. Have you ever seen a psychiatrist? ☐ Yes ☐ No
B. Have you ever received counseling for emotional problems? ☐ Yes ☐ No

If you answered YES to either A or B, please give the name of the doctor and/or therapist and give the dates in which the person was seen or diagnosis was given.

_____

_____

_____

_____

_____

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3. History of behavioral or emotional problems

Have you been diagnosed with a mental health problem such as ADHD? ☐ Yes ☐ No
If yes give the name of the diagnosis: _____, _____, _____.

4. History of behavioral or emotional problems

Have you ever been hospitalized? ☐ Yes ☐ No
If YES give dates, and locations below.

Hospitalizations

5. History of Suicidal attempts or Gestures?

Have you ever attempted to kill yourself? ☐ Yes ☐ No
If yes, please describe the event and give the dates.

Suicidal Attempts or Gestures? Please describe:

6. History of Psychiatric Medications?
Have you ever taken psychiatric medications? ☐ Yes ☐ No
If yes, please give the name of the medications and any good or bad effects.

Name of the medication	Dose	Good or Bad effects

7. History of substance abuse?
Have you ever taken illegal drugs? ☐ Yes ☐ No
If yes, please describe and give the names of the drugs used.

Substance/other Abuse History:

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8. **Any known drug allergies?** ☐ Yes ☐ No If yes, please describe_____.

9. **List All Current Medications Below:**

Name	Dose	How often is the medication taken

10. **List All medical problems below:**

Have you had any surgeries?

Who is your family doctor?

Date of last visit?

11. **Do any family members have emotional problems?** ☐ Yes ☐ No

A. If yes, please list family relationship and describe the problem or diagnosis.

Relation	Problem

Does any one in the family have a diagnosis or bipolar disorder. ☐ Yes ☐ No

Personal/Social Hx:

Is their any history of physical, sexual, or emotional abuse? ☐ Yes ☐ No

How far did you go in school? _____

Are you currently employed? ☐ Yes ☐ No
If No how do you support your self. _____

What type of work do you do?_____

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Give names ages and relationship of all member who live in your home:

Name	Age	Relationship

How long have you live where you are living now? _____
Who is the legal guardian? _____

Do you have any legal charges pending? ☐ Yes ☐ No
If yes, please describe. _____