Mind
Matter

Intake Questionnaire

Name: ____

DOB: ______________________ **Age:** ________

Physical Address:

____

____

Email Address: ____________________________________

Phone: ______________________ **SSN:** __________________________

Marital Status: ______________________

Employment Status: ____________________ **Employer:** _______________________

Religious Affiliations: ____

Primary Care Physician: ____

Pharmacy: ____

Emergency Contact: _________________________ **Relationship:** _________________

Phone: ___________________ **Email:** ___________________________________

Chief Complaint: What is your primary reason for seeking psychiatric consultation? Please describe the following:

1) How long you have had these symptoms?
2) Briefly describe the event(s) that prescribed them
3) Briefly describe the periods of time when symptoms seem better
4) How have the symptoms changed over time?

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Past Psychiatric History:

Have you had psychiatric treatment in the past? If yes, Where?

____

What kind of treatment have you had?

1. Individual Psychotherapy? If yes, when?

   ____

2. Group Psychotherapy? If yes, when, and where?

   ____

3. Family/Couples Therapy? If yes, when, and where?

   ____

Allergies:

____

Current Medications:

Name	Dosage	Reason	Prescriber	Other

Past Medications:

Name	Dosage	Reason	Prescriber	Other

Have you ever been hospitalized for psychiatric reasons? Yes ☐ No ☐

If yes:

Name of Facility	**Date**	**Duration**	**Reason**

Have you ever thought of committing suicide? If yes, when was the last time and what was the thought? Did you have a plan?

Have you ever attempted suicide? If yes, when and under what circumstances?

Have you ever intentionally hurt yourself? If yes, how did you do it and how often? Do you still do it?

Do you currently or have you in the past used any alcohol, illegal substances, or misused prescription drugs? If yes, please specify below?

Substance	When	Quantity	Frequency	Last used	Effects

Have you ever received treatment for alcohol or substance abuse? If yes:

Organization	Date	Inpatient/Outpatient/12-step	Was it helpful?

Have you ever been a victim of physical, sexual, emotional, or financial abuse?

If yes:

By Whom	Type of Abuse	Date	Duration

Have you ever been accused of or feel that you may have contributed to the abuse of another person? If yes, please elaborate:

Have you experienced any other event in your life that you feel may have been traumatic for you?

Medical History:

Current Medical Concerns:

Medical Hospitalizations:

Surgeries:

Other:

Please check or circle each bullet that applies to you:

Head Injury/ Loss of Consciousness	Chest problems
Heart problems	Growth/endocrine problems/ Diabetes
Seizures/Convulsions	Stomach or bowel problems
Rheumatic fever/strep infections	Serious accidents/fractures
Other neurological problems	Urinary or bladder problems
Liver/Kidney problems	Childhood measles/mumps/Shingles
Ear, nose, or throat problems	Gynecological/menstrual problems
Skin problems	Chicken pox
Dental problems	Infertility problems
Joint/limb problems	Cancer
Asthma	High Cholesterol
Hearing/vision problems	High/Low Blood Pressure

Most Recent Physical Exam:

Date: ______________________

Result: ____

Family Psychiatric History:

Has any family member had any of the following? Please indicate which family member(s) beside each.

Depression	
ADHD/ADD	
Mania/Bipolar Disorder	
Learning Disability	
Suicidal thoughts/urges/behaviors	
Coordination problems	
Anxiety	
Mental Retardation	
Panic Attacks	
Autism/Asperger’s Disorder/PDD	
Obsessions/Compulsions	
Sleep Disorder	
Rituals	
Drug Use	
Movement Disorders	
Alcohol Use	
Tics	

Psychosis	
Unusual noises/vocalizations	
Legal problems	
Eating Disorder	
Psychiatric hospitalizations	

Other:

____

Family Medical History:

Please list significant medical issues on the maternal side of your family:

____

Please list significant medical issues on the paternal side of your family:

____

Other: (please use the remaining space to describe any other concerns you would like to address)

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____

Please note below if you have you experienced any of the following?

Problem	Never	In Past	Occasionally	Often	Daily
Depressed Mood					
Appetite Disturbance					
Sleep Disturbance					
Elimination Disturbance					
Fatigue/Low Energy					
Psychomotor Retardation					
Poor Concentration					
Poor Grooming					
Mood Swings					
Agitation					
Emotionality					
Irritability					
Generalized Anxiety					

Panic Attacks					
Phobias					
Obsessions/Com pulsions					
Bingeing/Purging					
Laxative/Diuretic Abuse					
Anorexia					
Paranoid Ideation					
Loose Associations					
Delusions					
Hallucinations					
Aggressive Behaviors					
Conduct Problems					
Oppositional Behavior					
Sexual Dysfunction					
Grief					
Hopelessness					

Social Isolation					
Worthlessness					
Guilt					
Elevated Mood					
Hyperactivity					
Dissociative States					
Somatic Complaints					
Self-Mutilation					
Significant Weight Loss					
Significant Weight Gain					