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Patient Intake Questionnaire

Please fill out and bring it with you to your first appointment.

Allergies:

_____
_____

Medical Problems / Past Surgeries:

_____
_____
_____
_____
_____
_____

Medications:

Please list ALL medications (including supplements or over the counter medications)

Medication / dose / scheduling	**Reason for taking**	**Date started (approx. year if unknown)**

Pharmacy: (Name and number)

_____

Spiritual / Cultural:

Do you have any beliefs, practices, rituals or special needs that I need to know in planning your treatment and care? If yes, please explain:

_____

_____

_____

_____

Nutrition:

Any history or current eating disorders? If yes, please explain:

_____

_____

_____

_____

Trauma/Abuse:

Any history or current abuse / trauma? If yes, please explain:

_____

_____

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_____

Legal History:

If yes, please list charges, history of arrests, length of time in jail, any pending legal issues:

_____

_____

_____

_____

Substance Abuse (legal/illegal/prescriptions):

If yes, please list substance, frequency of use, any rehab/detox programs, periods of sobriety, last use:

_____

_____

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_____

Mental Health Treatment:

History of Inpatient hospitalizations: Please discuss where hospitalized, length of stay, reason for hospitalization.

_____
_____
_____
_____

History of Outpatient mental heath treatment: Please list previous providers, when treatment began and length of treatment.

_____
_____
_____
_____

History of suicide attempts or self injurious behaviors (ie/ cutting, burning, etc)

_____
_____
_____
_____

Previous medication trials. Please list names, doses, length of time on med, reason stopped and any side effects/adverse reactions.

_____
_____
_____
_____

History of ECT, VNS or TMS treatments If so, please explain and how did you respond to treatments.

_____
_____
_____
_____

Family History:

Please list any general medical issues in any 1st degree relatives (ie/ grandparents, parents, siblings):

____

____

____

____

Have any of your blood relatives been diagnosed with a mental illness? Yes No

If yes, please indicate their relationship to you, and if known, diagnosis and treatment:

Relative and relationship to you	**Diagnosis (circle all that apply)**	**Treatment (circle all that apply if known)**
	Major Depression Bipolar disorder Anxiety disorder Psychosis Addictions: ______________________ Other: ___________________________	Therapy/counseling Medication Hospitalization
	Major Depression Bipolar disorder Anxiety disorder Psychosis Addictions: ______________________ Other: ___________________________	Therapy/counseling Medication Hospitalization
	Major Depression Bipolar disorder Anxiety disorder Psychosis Addictions: ______________________ Other: ___________________________	Therapy/counseling Medication Hospitalization
	Major Depression Bipolar disorder Anxiety disorder Psychosis Addictions: ______________________ Other: ___________________________	Therapy/counseling Medication Hospitalization

Have any of your blood relatives committed suicide? Yes No

If yes, please list their sex, relationship to you and age at suicide:

____

____

____

____

FOR WOMEN - Reproductive history:

Age of first menstrual period? _____

Have you ever experienced PMS mood symptoms or Premenstrual Dysphoric Disorder (PMDD) ? If yes, please explain:

_____

_____

_____

_____

Have you ever taken hormonal contraceptives? Did they alleviate or worsen any PMS or PMDD symptoms?

_____

_____

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_____

Please list all pregnancies and outcomes (ie/ live births, miscarriages, abortions, stillbirths). Any difficulties during/after pregnancy. Medications during/after pregnancy. Any mental health related issues during/after pregnancy. If yes, please explain:

_____

_____

_____

_____

Have any of your female blood relatives suffered from mental illness within a year of giving birth? If yes, please indicate who, relationship to you, diagnoses and treatment

_____

_____

_____

_____