Ohio County HEALTHCARE Behavioral Health

Intake Questionnaire for New Adult Patients

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All information that you provide us will be kept confidential as required by state law and federal law.

Today's Date: _____

Name: _____ **DOB:** _____ **Age:** _____

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Social Security #: _____ **Home Phone:** _____ **Cell #** _____

Martial Status: (Please circle one) **Single Married Widowed Divorced Remarried Engaged Separated Cohabitating**

If applicable, please complete the following:
Partner/Spouse's Name: _____ **Age:** _____ **Occupation:** _____

If you have Children, Please list their Names & Ages:
Name: _____ **Age:** _____ **Name:** _____ **Age:** _____
Name: _____ **Age:** _____ **Name:** _____ **Age:** _____
Name: _____ **Age:** _____ **Name:** _____ **Age:** _____

Who currently lives at your residence (adults & children):
Name: _____ **Sex:** _____ **Age:** _____
Name: _____ **Sex:** _____ **Age:** _____
Name: _____ **Sex:** _____ **Age:** _____
Name: _____ **Sex:** _____ **Age:** _____
Name: _____ **Sex:** _____ **Age:** _____
Name: _____ **Sex:** _____ **Age:** _____

In your own words, describe the current problems as you see them:
_____
_____
_____
_____
_____

How long has this been going on: _____

What made you come in at this time: _____
_____
_____

What do you hope to gain from this evaluation and/or counseling? _____
_____
_____

If you had difficulties in the past, what have you done to cope? Was it helpful? _____
_____
_____

Symptoms: Please check any symptoms or experiences that you have had *in the last month*

☐ Difficulty falling asleep ☐ Difficulty getting out of bed ☐ Difficulty staying asleep
☐ Not feeling rested in the mornings Average hours of sleep per night_____

_____

☐ Persistent loss of interest in previous enjoyed activities ☐ Withdrawing from people
☐ Spending increased time alone ☐ Depressed mood ☐ Feeling Numb
☐ Rapid mood changes ☐ Irritability ☐ Anxiety ☐ Panic attacks
☐ Frequent feeling of guilt ☐ Avoid people, places activities or specific things
☐ Difficulty leaving your home ☐ Outbursts of Anger
☐ Fear of Certain objects or situations (i.e., flying, heights, bugs) Describe: _____
☐ Repetitive behaviors of mental acts (i.e., counting, checking doors, washing hands)

_____

☐ Worthlessness ☐ Sadness ☐ Fear ☐ Hopelessness ☐ Helplessness
☐ Feeling or acting like a different person

_____

☐ Changes in eating/appetite ☐ eating more ☐ eating less ☐ Voluntary vomiting
☐ Use of laxatives ☐ excessive exercise to avoid weight gain ☐ Binge eating
☐ Are you trying to lose weight? ☐ Yes ☐ No ☐ Weight Loss/_____lbs. ☐ Weight Gain/_____lbs.

_____

☐ Difficulty catching your breath ☐ Increase muscle tension ☐ Unusual sweating
☐ Easily startled, feeling "jumpy" ☐ Increased energy ☐ Decreased energy
☐ Tremor ☐ Dizziness ☐ Frequent worry ☐ Physical sensations others don't have
☐ Racing thoughts ☐ Intrusive memories

_____

☐ Difficulty concentrating or thinking ☐ Large gaps in Memory ☐ Flashbacks ☐ Nightmares
☐ Thoughts about harming or killing yourself ☐ Thoughts about harming or killing someone else

_____

☐ Feeling as if you were outside yourself, detached, observing what you are doing
☐ Feeling puzzled as to what is real and unreal
☐ Persistent, repetitive, intrusive thoughts, impulses or images
☐ Unusual visual experiences such as flashes of light, shadows

☐ Hear voices when no one is present ☐ Feeling that your thoughts are controlled or placed in your mind
☐ Feeling that the television or the radio is communicating with you ☐ Difficulty problem solving
☐ Difficulty meeting role expectations ☐ Dependency on others ☐ Self-mutilation/cutting
☐ Manipulation of others to fulfill your own desires ☐ Inappropriate expression of anger
☐ difficulty or inability to say "NO" to others ☐ Ineffective communication
☐ Sense of lack of control ☐ Decreased ability to handle stress ☐ Abusive relationship
☐ Difficulty expressing emotions ☐ Concerns about your sexuality

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Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☒ I choose not to answer

Please describe any other symptoms or experiences you have had problems with:

_____
_____
_____
_____

Have you seen a counselor, psychologist, psychiatrist, or other mental health professional before? Please List:

Name of Therapist: _____ **Date of treatment:** _____
Reason for seeking help: _____

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Reason for seeking help: _____

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Reason for seeking help: _____

Are you CURRENTLY taking PSYCHIATRIC medication? ☐ **NO** ☐ **YES** **If YES, Please List:**

Medication	Dosage	How long have you been taking it?	Has it been helpful?

Are you CURRENTLY taking NON-PSYCHIATRIC medication? ☐ **NO** ☐ **YES** **If YES, Please List:**

Medication	Dosage	How long have you been taking it?

Have you been on PSYCHIATRIC medications in the past? ☐ **NO** ☐ **YES** **If YES, Please List:**

Medications	Dosage	First/Last time you took it	Effect of Medication

Have you been hospitalized for psychiatric reasons? ☐ **NO** ☐ **YES** **If YES, Please Describe:**

Hospital	Dates	Reason

Have you ever attempted suicide? ☐ **NO** ☐ **YES** **If YES, Please Describe:**

_____
_____
_____
_____

MEDICAL HISTORY

Are you CURRENTLY under treatment for any medical conditions? ☐ **NO** ☐ **YES** **If YES, Please Describe:**

_____
_____
_____
_____
_____

List any PRIOR illnesses, operations and accidents:

_____
_____
_____
_____
_____
_____

FAMILY HISTORY

Father Age: _____ ☐ Living ☐ Deceased Cause of Death_____
If Deceased, HIS age at time of Death: _____ YOUR age at time of his death: _____
His Occupation: _____ Health: _____
Frequency of contact with Him: _____ Are you/Have you been close to Him? ☐ NO ☐ YES

Mother Age: _____ ☐ Living ☐ Deceased Cause of Death_____
If Deceased, HER age at time of Death: _____ YOUR age at time of her death: _____
Her Occupation: _____ Health: _____
Frequency of contact with Her: _____ Are you/Have you been close to Her? ☐ NO ☐ YES

Brothers and Sisters

Name	Sex	Age	Whereabouts	Are you Close to Him/Her?
				☐ NO ☐ YES
				☐ NO ☐ YES
				☐ NO ☐ YES
				☐ NO ☐ YES

During your childhood, did you live any significant period of time with anyone other than your natural parents?
☐ **NO** ☐ **YES** If so, please give the persons name and relationship:

Name: _____ Relationship to you: _____

Please place a check mark in the appropriate box if these are or have been present in your relatives

	Children	Brothers	Sisters	Father	Mother	Uncle/Aunt	Grandparents
Nervous Problems							
Depression							
Hyperactivity							
Psychiatric Medication							
Psychiatric Hospitalization							
Suicide Attempt							
Death by Suicide							
Death by Suicide							
Drinking Problem							

Social History

Past Martial History: Have you been married previously? If Yes, please describe:

When? _____ How long? _____
When? _____ How long? _____

Education

Highest grade level completed: _____
Degree obtained, if applicable: _____
Did you have any disciplinary problems in school? ☐ NO ☐ YES
If Yes, Please explain:

_____

Were you considered hyperactive/ADHD in school: _____
If yes, were/are you on any medication? _____
If so, Which medication? _____

Have you served in the military? _____
If yes, please describe briefly: _____
_____

What type of discharge separation) did you get? _____

Employment

Are you currently employed? ☐ NO ☐ YES
If yes, employer's name: _____
What type of work do you do? _____

Employment History (most recent first)

Type of Job	Dates	Reason for Leaving

Have you have arrested? ☐ NO ☐ YES
If Yes, please describe: _____

Do you have a religion affiliation? ☐ NO ☐ YES
If Yes, please describe: _____

What kind of social activities do you participate in? _____

What do you turn for help with your problems? _____

Have you ever been abused?
☐ Verbally ☐ Emotionally ☐ Physically ☐ Sexually ☐ Neglected
Please Describe: _____
_____

SUBSTANCE ABUSE

Alcohol

Do you drink alcohol? ☐ NO ☐ YES If yes, age of first use: _____
How much do you drink? _____
How often do you drink? _____
Have you ever passed out from drinking? _____ How often: _____
Have you ever blacked out from drinking? _____ How often: _____
Have you ever had the "shakes"? _____ How often: _____
Have you ever felt you should cut down on your drinking/drug use? _____
Have many people annoyed you by criticizing your drinking/drug use? _____
Have you ever felt bad or guilty about your drinking/drug use? _____
Have you ever drank/used drugs in the morning to steady your nerves or to relieve a hangover? _____
Do you use tobacco? ☐ NO ☐ YES If yes, how often: _____

Other Drugs

Please indicate for each drug listed below

Drug	Ever Used?	Age at 1st Use	Time since last use	Approx use in last 30days

Is there anything else you would like us to know about you? ☐ NO ☐ YES

If yes, please explain: _____
_____
_____
_____
_____