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ADULT CLINICAL INTAKE QUESTIONNAIRE

Please answer all of the questions on the following pages. The information you provide will become part of your confidential record with this office and will not be released to anyone without your written permission.

Name ______________________________ Date of birth __________

Age ________ Gender ________ Primary physician ____________________

Marital status ______________ Name of spouse/partner ______________

Your occupation ________________ Employer/school ________________

What is the primary reason for your visit at this time?

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List the three behaviors or symptoms that concern you the most. Start with the most troubling first and work your way down.

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When did you first notice having these behaviors or symptoms?

____

____

What are you most worried might happen if things continue as they are?

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What are the most stressful things in your life that are affecting you right now?

Did you ever have similar behavioral or emotional problems that concerned you when you were younger?

If yes, please describe these problems, when they occurred, and what was done about them?

Have you ever seen anyone for help with behavioral or emotional problems?

If so, how old were you at the time?

Who did you see?

Did it help?

Have you ever taken medicines to help with behavioral or emotional problems?

If yes, how long ago?

Please list the medicines you have taken in the past (not your current medication):

Name of medication	Dose (mg)	How many times per day

List any medical problems for which you are currently being treated. Please indicate if a problem has been ongoing requiring regular or periodic care.

List any past hospitalizations you have had for medical, surgical, chemical dependency, or psychiatric reasons.

List any medications to which you are allergic or that you could not take due to intolerable side effects.

Please list all medications you are **currently taking**. Include birth control, vitamins, and over the counter drugs. Please include the name of the prescribing doctor.

Name of medication	Dose (mg)	How many times per day	Prescribing doctor

FAMILY HISTORY:

Has any relative on either parent's side of the family had any of the following?

Condition or event	Which family member?
Nervousness or panic	
Depression	
Obsessive-compulsive problems	
Bipolar disorder (manic depressive illness)	
Suicide	
Alcohol or drug problems	
Police record (arrests, jail)	
Schizophrenia	
Mental retardation	
Developmental problems (autism, Asperger's)	
Learning disorder (dyslexia)	
Attention problems (AD/HD)	
Tourette's or other tic problems	
Other (describe)	

HISTORY OF BEHAVIORAL OR EMOTIONAL EVENTS AND PROBLEMS:

Please place a check in front of all that apply to you:

- ☐ had to repeat a grade in school
- ☐ was in at least one special education class or an SE curriculum
- ☐ was told by teacher or other professional you have a learning disability
- ☐ have been in accelerated classes for smart kids

I experience the following at home, work, or school:

- ☐ often leave things unfinished
- ☐ am easily distracted
- ☐ have difficulty concentrating on reading or homework
- ☐ have difficulty sitting still

☐ feel restless or fidgety

☐ am impulsive; I sometimes act without thinking

☐ often misplace or lose things

☐ am easily forgetful and need frequent reminders

The following describe traits I have or things I have done:

☐ am unusually stubborn or self-willed

☐ have trouble conforming to rules/regulations

☐ tend to argue with my boss/coworkers

☐ lose my temper easily, sometimes breaks/throws things

☐ have shoplifted or stolen something

☐ have injured or killed a pet or small animal just for fun

☐ have broken or destroyed someone else's property (windows, cars, etc)

☐ have a reputation for starting fights?

☐ have pulled a knife or gun on someone

☐ have tried to steal things by threatening someone

☐ have tried to force another person to have sex

Check all of the following that apply to you:

☐ I smoke cigarettes regularly. If yes, how many packs per day? ____________

☐ I drink beer, wine, or other alcoholic beverages. If yes, what is the most you have drunk at one time?

____

☐ missed school (or was asked to leave) because of drinking

☐ missed work (or was asked to leave) because of drinking

☐ have sniffed glue, gasoline, or fumes to get high

☐ have smoked marijuana (pot, weed, grass)

☐ have used amphetamines (crystal meth, ice, speed)

☐ have used cocaine (coke, crack)

☐ have used hallucinogens (LSD, PCP, peyote, mescaline)

☐ have used heroin, opiates (junk, smack, horse, H)

☐ have abused prescription medication (roxys, oxys, pain, sleep, etc.)

☐ have abused sedatives, tranquilizers (downers)

☐ am regularly using some of the above substances now?

I have had a period of two weeks or longer (now or in the past) when I:

☐ seemed to be sad, depressed, moody or irritable

☐ didn’t feel much like eating or lost weight

☐ felt like eating more than usual or gained extra weight

☐ had trouble falling asleep or staying asleep

☐ slept more than usual or had trouble waking up

☐ withdrew from family and friends, talking less than usual

☐ lost interest in things I usually like to do

☐ felt tired all the time but wasn’t physically sick

☐ frequently complained of aches (headaches, stomachaches, etc.)

☐ felt guilty over things I really wasn’t to blame for

☐ felt worthless and thought I would be better off dead

☐ couldn’t concentrate on work/school as well

☐ talked about or tried to kill myself

☐ thought a lot about death or dying

☐ I am now feeling sad, blue, moody, or irritable

☐ I have experienced at least five of the items I have checked in this section continuously for the past two weeks or longer

I have had a period of at least one week or longer (now or in the past) when:

☐ was so overly happy or “high” that I got into trouble

☐ became more overactive than usual to the extent that it made others concerned

☐ talked faster or more constantly than usual

☐ had thoughts were going very fast (racing) in my head

☐ thought I had special powers to do remarkable things

☐ slept a lot less than usual without appearing or feeling tired

☐ was unable to concentrate on things as usual

☐ did extravagant things I later regretted (grand promises, travel, sex, spent money)

The following describe traits I have or things I have experienced:

☐ I consider myself to be an anxious person

☐ I have had an anxiety attack without apparent reason.
If yes, how often do you have these attacks?

____

☐ During an anxiety attack, I have trouble catching my breath

☐ My heart races too fast

☐ My face becomes flushed or my hands begin to sweat

☐ I tend to worry a lot

☐ I sometimes think too much about health concerns or illness

Please check the following that are true about you:

☐ I sometimes seem to have unusual and troublesome thoughts that I can't put out of my mind (getting hurt, germs, bugs, etc)

☐ I have special habits or rituals that seem excessive or unnecessary (counting things, touching, hand washing, etc)

☐ I check and recheck excessively on things already done, like turning off a light, or closing a door

☐ I tend to get highly upset when things are not in their exact place

☐ I think I am too fat?

☐ I have lost excessive weight intentionally

☐ I exercise with the intent to lose weight

☐ I have lost more then ten pounds intentionally

☐ I have gone on excessive eating binges

☐ I have made myself vomit after binges or meals

☐ I have tried diet pills or laxatives to lose weight

☐ I have sudden, jerky movements, which are repetitive, like neck jerks, eye blinking, mouth twitches, shoulder shrugs, or tics

☐ I have now or in the past had a habit of making repetitive sounds such as sniffs, grunts, throat clearing, barking, etc.

☐ I have now or in the past had a habit of rocking my body or moving my fingers and hands in a repetitive way

Have you ever had beliefs that confused you such as (check the boxes that apply):

☐ thinking someone was out to get you?

☐ thinking that others could control your thoughts?

☐ hearing voices in your head that were telling you strange things?

☐ seeing visions that others can't see?

Have you ever had biofeedback or neurofeedback training/treatment? _____________

If yes, please describe why you were referred for biofeedback, the type you received to the best of your knowledge, and if it was effective.

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Thank your for taking the time to answer these important questions. This information is helpful to the doctor/therapist in understanding your needs and how to best be of help to you.