Westbrook Psychological Services
Integrative Care For Optimal Wellness

Intake Questionnaire New Patients (Adult)

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 confidential as required by state and federal law.

Date: _____ ***Email :*** _____

Name: _____ ***Date of Birth:*** _____ **Age**: _____

Home Address: _____ ***City/State/Zip code:*** _____

Home Phone: _____ ***Cellular/Alternate Phone:*** _____

Marital Status: single married separated divorced
remarried engaged widowed Cohabiting

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

Partner's Occupation: _____

IF YOU HAVE CHILDREN PLEASE LIST THEIR NAMES AND AGES:

#	Name	Sex	Age	#	Name	Sex	Age
1				4			
2				5			
3				6			

WHO CURRENTLY LIVES IN YOUR RESIDENCE (adults and children):

#	Name	Relation	Sex	Age	#	Name	Relation	Sex	Age
1					4				
2					5				
3					6				

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 staying asleep
☐ Difficulty getting out of bed	☐ Not feeling rested in the morning
Average hours of sleep per night:	
☐ Persistent loss of interest in previously enjoyed activities	
☐ Withdrawing from other people	☐ Spending increased time alone
☐ Depressed Mood	☐ Feeling Numb
☐ Rapid mood changes	☐ Irritability
☐ Anxiety	☐ Panic attacks
☐ Frequent feelings of guilt	☐ Avoiding people, places, activities or specific things
☐ Difficulty leaving your home	
☐ Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: _____	
☐ Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)	
☐ Outbursts of anger	
☐ Worthlessness	☐ Hopelessness
☐ Sadness	☐ Helplessness
☐ Fear	☐ 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? _____	
☐ Weight gain: _____ lbs	☐ Weight loss: _____ lbs.
☐ Difficulty catching your breath	☐ Increase muscle tension
☐ Unusual sweating	☐ Easily started, 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 else 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
☐ Manipulation of others to fulfill your own desires
☐ Inappropriate expression of anger
☐ Self-mutilation/cutting
☐ Difficulty or inability to say "no" to others
☐ Ineffective communication
☐ Sense of lack of control
☐ Decreased ability to handle stress
☐ Abusive relationship
☐ Difficulty expression emotions
☐ Concerns about your sexuality

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?
☐ No ☐ Yes If so:

Name of therapist: _____ Dates of Treatment
Reason for seeking help: _____ _____

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Reason for seeking help: _____ _____

Name of therapist: _____ Dates of Treatment
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** medication in the past? ☐ No ☐ Yes If YES, please list:

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

Have you been hospitalized for psychiatric reasons? ☐ No ☐ Yes If YES, describe:

Hospital	**Dates**	**Reason**

Have you ever attempted suicide? ☐ No ☐ Yes If YES, describe:

MEDICAL HISTORY

Are you **CURRENTLY** under treatment for any medical condition? ☐ No ☐ YesIf YES, describe:

List any PRIOR illnesses, operations and accidents

FAMILY HISTORY

Father: Age: ☐ Living ☐ Deceased Cause of death: YOUR age at time of his death Health:_____
If deceased, HIS age at the time of his death: _____
Occupation: _____
Frequency of contact with him: _____ Are you/Have you been close to him? _____

Mother: Age: ☐ Living ☐ Deceased Cause of death: YOUR age at time of her death Health:_____
If deceased, HER age at time of her death___ _____
Occupation: _____
Frequency of contact with her: _____ Are you/Have you been close to her? _____

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 persona's name and relationship to you

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							
Counseling							
Psychiatric Medication							
Psychiatric Hospitalization							
Suicide Attempt							
Death by Suicide							
Drinking Problem							

SOCIAL HISTORY

Past Marital 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? _____
If yes, please explain: _____
Were you considered hyperactive/ADHD in school? _____
If yes, were/are you on any medication? _____
If yes, were/are you on any medication? _____
If so, which medication? _____
What kinds of grades did you get in school? _____

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

What type of discharge (separation) did you get? _____

Employment

Are you currently employed? _____
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 been arrested? _____
If yes, please describe: _____

Do you have a religious affiliation? _____
If yes, what is it? _____

What kind of social activities do you participate in? _____

Who do you turn to for help with your problems? _____

Have you ever been abused?
☐ Verbally ☐ Emotionally ☐ Physically ☐ Sexually ☐ Neglected

Please describe: _____
_____

SUBSTANCE ABUSE

Alcohol

Do you drink alcohol? _____ 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 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 relieve a hangover? _____
Do you use tobacco? _____
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 30 days
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				

Is there anything else you would like us to know about you?

The Holmes-Rahe Scale

Read each of the events listed below, and **check the box** next to any even which has occurred in your life **in the last two (2) years.** There are no right or wrong answers. The aim is to identify which of these events you have experienced lately.

Life Events	Life Crisis Units	
Death of Spouse	100	
Divorce	73	
Marital Separation	65	
Gone to jail	63	
Death of close family member	63	
Personal injury or illness	53	
Marriage	50	
Fired at work	47	
Marital reconciliation	45	
Retirement	45	
Change in health of family member	44	
Pregnancy	40	
Sexual Difficulties	39	
Gain of new family member	39	
Business readjustment	39	
Change in financial state	38	
Death of a close friend	37	
Change to different line of work	36	
Increase in arguments with spouse	35	
Mortgage over $100,000	31	
Foreclosure of mortgage or loan	30	
Change in responsibilities at work	29	

Life Events	Life Crisis Units	
Son or daughter leaving home	29	
Trouble with in-laws	29	
Outstanding personal achievement	28	
Spouse begins or stops work	26	
Begin or end school	26	
Change in living conditions	25	
Revision in personal habits	24	
Trouble with boss	23	
Change in work hours or conditions	20	
Change in residence	20	
Change in schools	20	
Change in recreation	19	
Change in church activities	19	
Change in social activities	18	
Mortgage or loan less than $30,000	17	
Change in sleeping habits	16	
Change in number of family get-togethers	15	
Change in eating habits	15	
Vacation	13	
Christmas alone	12	
Minor violations of the law	11	

Your Total Score: _____

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EMERGENCY CONTACT

Name of Contact: _____

Relationship: _____

Contact Phone Number: _____

INSURANCE INFORMATION

Insurance Company:_____ Name of Insured:_____

Insured's Date of Birth: _____

Insured's Employer:_____ Policy Name: _____

Insured's Member ID #:_____ Insured's Group #:_____

Insured's Relationship to the Client:_____ Authorization # (if needed):_____

Customer Service Phone # (for MH/SA): _____

Address for Submitting Claims: _____

Who referred your child to my private practice? Please provide agency/professional's name & tel #:

_____

May I contact the agency/person to thank them for referring you? Yes No
Please initial:_____