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Patient Intake Questionnaire

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.

Patient Name: _____

Date of Birth: _____

Gender: Female ☐ Male ☐ Non-Binary: _____

Marital Status: Single ☐ Married ☐ Widowed ☐

Divorced ☐ Other ☐ Prefer Not To Say ☐

Email: _____

Home Address: _____

Phone Number: _____

* Please Note- Email correspondence is not considered to be a confidential medium of communication

Others living in your household	Relation to you

Are you currently employed? Yes ☐ No ☐

What is your current employment situation? _____

Beliefs

Do you consider yourself to be spiritual or religious? Yes ☐ No ☐

If yes, describe your faith or belief: _____

Medical History:

Allergies

Are you allergic to any medicines? **Yes** ☐ **No** ☐

If yes, please list: _____

_____

_____

Are you allergic to any other substances? **Yes** ☐ **No** ☐

If yes, please list:

What types of allergic reactions have you had?

Medical Illnesses

Have you had any illnesses in the past? **Yes** ☐ **No** ☐

If yes, which ones?

Do you have any illnesses at present? **Yes** ☐ **No** ☐

If yes, please list:

Date of your most recent physical examination:

Surgical History:

Have you had surgical operations or injuries? **Yes** ☐ **No** ☐

Have you ever had a head injury? **Yes** ☐ **No** ☐

Did you lose consciousness? **Yes** ☐ **No** ☐

Outpatient Psychotherapy Treatment

Have you ever been in therapy before? **Yes** ☐ **No** ☐

If yes, for what?
When and where did you receive treatment?

Name of previous psychotherapist/ practitioner:

Hospitalizations

Have you ever been hospitalized for a psychiatric disorder? **Yes** ☐ **No** ☐

Which medications have you taken in the past?

Name	Dose	Frequency	Prescribing Physician

Do you use non-prescription drugs? **Yes** ☐ **No** ☐

If yes, which ones? _____

_____

Do you or have you used recreational or illegal drugs? **Yes** ☐ **No** ☐

If yes, which drugs and how much? _____

_____

Do you drink alcohol? **Yes** ☐ **No** ☐

Do you smoke? **Yes** ☐ **No** ☐

If yes, what and how much? _____

Any uses of non-smoking forms of tobacco? **Yes** ☐ **No** ☐

If yes, which? _____

_____

Family Psychiatric History

Has anyone in your family had a psychiatric disorder? **Yes** ☐ **No** ☐

	Please Circle		List Family Member
Alcohol/Substance Abuse	Yes ☐	No ☐	_____
Anxiety	Yes ☐	No ☐	_____
Depression	Yes ☐	No ☐	_____
Domestic Violence	Yes ☐	No ☐	_____
Eating Disorders	Yes ☐	No ☐	_____
Obesity	Yes ☐	No ☐	_____
Obsessive Compulsive Behavior	Yes ☐	No ☐	
Post Traumatic Stress Disorder (PTSD)	Yes ☐	No ☐	_____
Schizophrenia	Yes ☐	No ☐	_____
Suicide Attempts	Yes ☐	No ☐	_____
			_____

Are there any other family history or health concerns you would like to share with me?

Adaptive History
Which stresses have you overcome in the past?

What did you do to overcome your stressors?

Which coping mechanisms did you use?

What was the best period of your life? What are some of the highlights of your life?

What are your personal strengths?

What do you consider to be some of your personal challenges?

What would you like to accomplish out of your time in therapy?