New Patient Intake Questionnaire

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.

Preferred Name	Date of birth	Today's date

Preferred pronouns

- ☐ She/her
- ☐ He/him
- ☐ They/them
- ☐ I'd prefer not to say
- ☐ Other _____

Sex assigned at birth

- ☐ Female
- ☐ Male
- ☐ Intersex
- ☐ I'd prefer not to say

What are your main concerns today?

How long have you had these concerns?

☐ Since childhood/adolescence ☐ Only very recently ☐ For several years ☐ Within the last 6 months

What made you come in at this time?

What do you hope to achieve in our work together?

If you have had difficulties in the past, what has been helpful?

Please list all mental health diagnoses past and present

Diagnosis	Year(s) of Diagnosis	Did your treatment include the following		
		Therapy	Inpatient hospitalization	Medication
		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

If you have been hospitalized (inpatient) for psychiatric reasons, please describe

Hospital Name	Duration of Treatment	Reason

Most Recent Therapist	Duration of Treatment	Name of Clinic

Once weekly for at least 6 weeks? ☐ Y ☐ N

Type of therapy (CBT, DBT, etc.)

Most Recent Psychiatrist	Duration of Treatment	Name of Clinic

Most Recent Primary Care Provider	Duration of Treatment	Name of Clinic

Have you ever had ECT or TMS treatment before? ☐ Y ☐ N

In the past 2 weeks, how much have your mental health symptoms interfered in the following areas of life?

Area of life	My symptoms interfered										
	Not at all		A little		Moderately			Very Much		Severely	
Family life and home responsibilities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Work or school (includes any regularly scheduled activities out of the home)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Social or leisure activities (includes activities with friends , hobbies, or attending church)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

Current Relationship Status

☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Widowed/Widower ☐ Other

Attachment style

- ☐ Secure: "It's relatively easy for me to be with others while keeping my autonomy."
- ☐ Avoidant: "I want a close relationship but find it difficult to trust or depend on others."
- ☐ Anxious: "I want complete emotional intimacy but find others are reluctant to get as close as I would like."
- ☐ Dismissive: "I am comfortable without close emotional relationships."
- ☐ Other or unknown

Who do you currently live with? (spouse, children, roommates, etc.)

Who do you turn to for help with your problems?

To what extent, if any, is religion part of your life? (optional)

What was your family's religion growing up? (optional)

What is your highest level of education completed or currently pursuing?

☐ Other ☐ High School/GED ☐ Associates ☐ Bachelors ☐ Masters ☐ Doctorate ☐ Trade School

Did you have disciplinary problems in school, describe if applicable

What were the majority of your grades in school? (check all that apply)

☐ A's ☐ B's ☐ C's ☐ D's ☐ F's

Current occupation and employer

Current income source

☐ Self ☐ Spouse ☐ Disability ☐ Other

Check any past or current medical conditions you have

- ○ Seizure
- ○ Stroke
- ○ Concussion/TBI
- ○ Metal in head
- ○ Coronary Artery Disease
- ○ Heart Failure
- ○ Arrhythmia
- ○ Hypertension
- ○ COPD
- ○ Sleep Apnea
- ○ Gastric reflux
- ○ IBS/IBD
- ○ STI/STD
- ○ Kidney Disease
- ○ PCOS
- ○ Anemia
- ○ Cancer
- ○ Autoimmune Disease
- ○ Diabetes
- ○ Thyroid/Parathyroid Disorders
- ○ Low Testosterone
- ○ Premature birth
- ○ Prenatal Drug Exposure
- ○ Sensory sensitivity
- ○ History of IEP
- ○ Delayed (speech, walking, feeding, growth)

I have biological relatives with the following mental illnesses

- ○ Depression
- ○ Schizophrenia
- ○ Insomnia
- ○ Suicidal Ideation
- ○ Bipolar affective disorder
- ○ OCD
- ○ Autism spectrum disorder (ASD)
- ○ Substance use disorder
- ○ Dementia
- ○ Anxiety
- ○ ADHD/ADD

Are you currently taking **non-psychiatric** medications?

Medication	Dosage	Duration Taken

Are you currently taking **psychiatric** medications?

Medication	Dosage	Duration	What has been your response?

Have you been on psychiatric medication in the past that you no longer take?

Medication	>6 week trial	Dosage	Duration	Reason for discontinuation
	☐ Y ☐ N			◯ Ineffective ◯ Side effects
	☐ Y ☐ N			◯ Ineffective ◯ Side effects
	☐ Y ☐ N			◯ Ineffective ◯ Side effects
	☐ Y ☐ N			◯ Ineffective ◯ Side effects
	☐ Y ☐ N			◯ Ineffective ◯ Side effects

Please list any allergies to medications below.

Medication	Reaction

	Over the past 6 months, what best describes how you have felt and conducted yourself? **How often do you...**	Never	Rarely	Sometimes	Often	Very Often
A1	Have difficulty concentrating on what people say to you, even when they are speaking to you directly?	0	1	2	3	5
	Leave your seat in meetings or other situations in which you are expected to remain seated?	0	1	2	3	5
	Have difficulty unwinding and relaxing when you have time to yourself?	0	1	2	3	5
	Find yourself finishing the sentences of the people you are talking to before they can finish them themselves?	0	1	1	2	2
	Put things off until the last minute?	0	1	2	3	4
	Depend on others to keep your life in order and attend to details?	0	1	2	2	3

	Over the past 6 months, what best describes how you have felt and conducted yourself? **How often do you...**	Never	Rarely	Sometimes	Often	Very Often
A2	Perform well in emergency situations or under high pressure?	0	1	2	3	4
	Feel intense anger but the feeling passes suddenly?	0	1	2	3	4
	Have trouble remembering verbally assigned tasks that have many steps?	0	1	2	3	4
	Reread a page over and over again because it won't sink in?	0	1	2	3	4
	Find yourself moving (tapping foot, twirling hair, biting or picking at nails/skin, shifting in chair, or rocking back and forth) when you feel overwhelmed or need to focus?	0	1	2	3	4
	Perform well on complicated or complex problems but when it comes to simple things you tend to make mistakes?	0	1	2	3	4
	Find your attention narrows so much that you're oblivious to your surroundings, while other times it's so broad that everything distracts you?	0	1	2	3	4
	Have a hard time completing one task at a time and tend to bounce from task to task?	0	1	2	3	4
	Have trouble moving past negative criticism?	0	1	2	3	4
	Misplace necessary items (e.g. keys, wallet, phone, glasses, pens) unless you follow a strict routine?	0	1	2	3	4
	Underestimate the time needed to finish even common tasks?	0	1	2	3	4
	Have trouble sleeping because you cannot turn my mind off.	0	1	2	3	4

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
B1	Little interest or pleasure in doing things	0	1	2	3
	Feeling down, depressed, or hopeless	0	1	2	3
	Trouble falling/staying asleep, sleeping too much	0	1	2	3
	Feeling tired or having little energy	0	1	2	3
	Poor appetite or overeating	0	1	2	3
	Feeling bad about yourself – or that you're a failure or have let yourself or your family down	0	1	2	3
	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3

B1

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Moving or speaking so slowly that other people could have noticed, or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

How difficult have these problems made it for you to work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

If marking any of these three boxes, please fill out section B2. If not, skip to section C.

C

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3

How difficult have these problems made it for you to work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

From the list below, please add up the number of adverse experiences you had prior to your 18th birthday and put the total number at the bottom.

D

- Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you? ☐
- Did you lose a parent through divorce, abandonment, death, or other reason? ☐
- Did you live with anyone who was depressed, mentally ill, or attempted suicide? ☐
- Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs? ☐
- Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other? ☐
- Did you live with anyone who went to jail or prison? ☐
- Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way? ☐
- Did you feel that no one in your family loved you or thought you were special? ☐
- Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)? ☐

Your ACE score is the total number of yes responses. ☐

During any given month in the last few years, how often do you experience the following?	Not at all	Less than a day or two	Several days	More than half the days	Nearly every day
E Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4
E Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4
F Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4
F Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4
G Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4
G Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4
H Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4
I Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4
I Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4

	During any given month in the last few years, how often do you experience the following?	Not at all	Less than a day or two	Several days	More than half the days	Nearly every day
J	Not knowing who you really are or what you want out of life?	0	1	2	3	4
	Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4
	Feeling temped to self-harm?	0	1	2	3	4
K	I usually concentrate more on the whole picture, rather than the small details.	0	1	2	3	4
	I like to collect information about a specific category of things (e.g., plants, animals, sports, cars)?	0	1	2	3	4
	Not knowing how to tell if someone listening to me is getting bored?	0	1	2	3	4
L	I am preoccupied with a desire to be thinner.	0	1	2	3	4
	I have lost over 14 lbs. within a 3 month period (0 = no, 4 = yes).	0	1	2	3	4
	I worry I've lost control over how much I eat.	0	1	2	3	4
M1	Smoking any cigarettes, a cigar, or pipe, or using cannabis or chewing tobacco?	0	1	2	3	4
	Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4
	Using any of the following medicines without a doctor's prescription, in greater amounts or longer than prescribed: • Opioid painkillers (Vicodin, heroin, morphine, methadone, codeine) • Stimulants (Ritalin, Adderall, speed, diet pills) • Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol) • Inhalants (nitrous, glue, petrol, paint thinner) • Hallucinogens (LSD, acid, mushrooms, PCP, Special K) • Cocaine (coke, crack) • Club drugs (ecstasy, molly)	0	1	2	3	4

If marking any of these boxes, please fill out section M2. If not, skip to section N.

	In the past 3 months...	Never	Once or twice	Monthly	Weekly	Almost Daily
M2	How often do you use this substance?	0	4	5	6	7
	How often strong desire to use this substance?	0	4	5	6	7
	How often has this substance led to health, social, legal, or financial problems?	0	4	5	6	7
	How often have you failed to do what is normally expected of you due to use this substance?	0	4	5	6	7

M2

In the past 3 months...	no, never	yes, but not in the past 3 months	yes, in the past 3 months
Has anyone ever expressed concern about your use of this substance?	0	3	6
Have you ever tried and failed to control, cut down, or stop using this substance?	0	3	6

N

Do you have problems sleeping?

If yes, please fill out section N. If not, skip to section O.

How long have you had sleep problems?

☐ Recently ☐ 1-3 months ☐ 6-12 months ☐ 1-5 years ☐ lifelong

On average, how many nights per week do you have sleep problems?

☐ Several days ☐ More than half the days ☐ Nearly every day

On average, how many hours do you sleep each night?

☐ 0-2 ☐ 3-4 ☐ 5-6 ☐ 7-8 ☐ 9-10 ☐ 11+

Which of the following best describes your sleep pattern (check all that apply)?

☐ I have trouble falling asleep.
☐ I wake up frequently at night.
☐ I don't feel rested the next day.
☐ I have trauma themed nightmares.

O

How strongly do you agree with the following?	Disagree				Agree
I am worried that Psychiatric mediaitons could cause long term problems.	1	2	3	4	5
I feel very uncomforatlbe when I am on medications of any kind.	1	2	3	4	5
I would much rather take an herbal supplement than a perscription medicaiton.	1	2	3	4	5
I often forget to take prescribed medicaitons.	1	2	3	4	5
I have felt before that my psychiatric medicaiton was selected without much thought.	1	2	3	4	5
I spend too much of my time worrying about my health?	1	2	3	4	5