Name: Last_____ First_____ DOB:_____ Today's Date_____

INTAKE QUESTIONNAIRE/PROBLEM LIST

It is our sincere desire to help you with any problems that concern you. In order for us to understand your concerns and review your past medical history and other life factors that affect your health, we ask that you complete this form as accurately as you can. We realize that these questions are very personal. If there are any questions you are not comfortable answering, just skip over them. All information collected is kept strictly confidential. If you need more room to explain something you may write on the back side of this form.

1. What is the main reason for your visit? _____
_____

2. What are you hoping for from this consultation? _____
_____

3. How is your general health? ___excellent ___good ___fair ___poor

4. Past medical illnesses: Check any serious past medical illnesses you have had and give details:
___ heart ___ lung ____gastrointestinal ___ psychiatric ___neurologic ___ chronic pain
___ cancer ___ accidents/serious injury ___ allergies ___ diabetes ___ thyroid problems
If you have checked any above, please give details: _____
_____
Any other diagnoses you have been given:_____
_____

5. Past Surgeries: (approximate dates and types of procedures)
_____
_____

6. Hospitalizations other than for surgery: (approximate dates and reasons for hospitalizations_____
_____

Current Medications: Include prescription drugs and over-the-counter medicines and supplements

Name of medication	Dosage	How taken

7. Drug Allergies:

Drug	**Adverse Reaction to Drug**

8. Habits:

Caffeine: (coffee, tea, soda) How many servings per day total? _____
Tobacco: Do you smoke? ___ Yes ___ No If yes, how many times per day? _____
Alcohol: Do you drink alcohol? ___ Yes ___ No If yes, how often? _____
Recreational drugs: Do you use any recreational drugs (marijuana, heroin, crack/cocaine, other)
____ Yes ___ No If yes, what and how often _____

9. Problems: Check all that apply:

___ Depressed/Sad ___Angry/Irritable/Hostile ___Feeling hopeless ___Trouble falling asleep
___ Trouble staying asleep ___ Sleeping more than usual ___ Drowsy during the day
___ Low energy ___ Decreased appetite ___ Increased appetite ___Decreased weight (not due to dieting)
___ Increased appetite ___Decreased sexual interest ___Increased sexual interest
___ Decline in memory ___ Decline in concentration ___ Easily distracted/Confused
___ Recent losses ___Anxious/Worried ___ Thoughts of or intent to commit suicide
___ Racing thoughts ___ Seizures ___Hearing voices/Seeing things that are not there
___ Restlessness___ Feeling compelled to do senseless things over and over
___ Unable to control impulses___ Feeling rejected by others ___ Family history of psychiatric issues

10. Traumatic Events: (Include any emotional, physical, sexual or traumatic events witnessed)

Childhood Trauma: _____
_____
_____

Adult Trauma: _____
_____
_____

11. Spiritual Life:

Is there a particular spiritual belief system that is meaningful to you? ___ Yes ___ No

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