Conlon Psychological Services, PLLC

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Intake Questionnaire for New Patients (Adult) – Part 1

Instructions: To assist me in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank.

Today's Date:	
Name:	Date of Birth: Age:
Home Address:	City/State/Zip:
Home phone: ____________________________ OK to leave message? Yes No	Cell/Alt. phone: ____________________________ OK to leave message? Yes No
Employed Retired Student Homemaker Other	Veteran/Military Family Member? Yes No
Employer/School:	Occupation/Major:
City/State	Years at this job:
Work phone: ____________________________ OK to leave a message? Yes No	Best Phone Contact: Home Cell Work

Marital status: Single Married Separated Divorced Remarried Engaged Widowed Cohabitating

If applicable, please complete the following:

Name of Spouse/Partner:_____________Age: ______________ Occupation: _______________________

If married, is this your first marriage? Yes No

If No, which marriage is it for you? 2 3 4 5+

If you have children, please complete

#	Child's Name	Gender	Age	Lives in home?	#	Child's Name	Gender	Age	Lives in home?
1					3				
2					4				

Who else currently lives in your home?

#	Name	Gender	Age	Relation	#	Name	Gender	Age	Relation
1					3				
2					4				

EMERGENCY CONTACT:	Name:	Phone:	Relationship:

Who gave you my name to call? ________________________________

May I have your permission to thank this person for the referral? Yes No

Please pay for service at the time it is provided. I accept cash, check or credit card. Thank you

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Description of the problems that brought you here today:

In your own words, describe the current problems as you see them:

____

____

____

On a scale below, please estimate the severity of your problem(s):

Mildly upsetting		Moderately upsetting			Very severe		Extremely Severe		Totally Incapacitating
1	2	3	4	5	6	7	8	9	10

How long has this been going on? ____

What made you come in at this time? ____

____

What seems to worsen your problems?____

____

What have you tried that has been helpful? ____________________________________

____

If you had difficulties in the past, what have you done to cope?__________________________

____

Was it helpful? Yes No

How satisfied are you with your life as a whole these days?

Not at all satisfied									Very satisfied
1	2	3	4	5	6	7	8	9	10

How would you rate your overall level of tension during the past month?

Relaxed									Tense
1	2	3	4	5	6	7	8	9	10

Expectations regarding therapy:

In a few words. what do you think therapy is all about?

____

How long do you think your therapy should last?

____

What personal qualities do you think the ideal therapist should possess?

____

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Symptoms

Please **check** any symptoms or experiences that you have had **in the last month**

- Difficulty falling asleep
- Difficulty getting out of bed
- Average hours of sleep per night:
- Difficulty staying asleep
- Not feeling rested in the morning

- Persistent loss of interest in previously enjoyed activities
- Withdrawing from other people
- Depressed mood
- Rapid mood changes
- Anxiety
- Frequent feelings of guilt
- Difficulty leaving your home
- Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)
- Spending increased time alone
- Feeling numb
- Irritability
- Panic attacks
- Avoiding people, places, activities or specific things
- Difficulty urinating in certain situations (bashful bladder)
- Saving things that I don't even want
- Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: ______________________________

- Worthlessness
- Sadness
- Fear
- Hopelessness
- Helplessness
- Feeling or acting like a different person

- Changes in eating/appetite
- Eating more
- Voluntary vomiting
- Excessive exercise to avoid weight gain
- Weight gain: _______ lbs.
- Eating less
- Use of laxatives
- Binge eating
- Are you trying to lose weight?
- Weight loss: ______ lbs.

- Difficulty catching your breath
- Difficulty concentrating or thinking
- Flashbacks
- Thoughts about harming or killing yourself
- Increase in muscle tension
- Large gaps in memory
- Nightmares
- 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

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- Difficulty problem solving
- Dependency on others
- Inappropriate expressions of anger
- Difficulty or inability to say "no" to others
- Sense of lack of control
- Abusive relationship
- Concerns about your sexuality
- Difficulty meeting role expectations
- Manipulation of others to fulfill your own desires
- Self-mutilation/cutting
- Ineffective communication
- Decreased ability to handle stress
- Difficulty expressing emotions

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O Gambling problem	O Pornography
O Compulsive shopping	O Affair(s)
O Shoplifting	O The need to know or things to be "just so"
O Petty theft	O Speeding/Reckless driving
O Overspending, difficulty managing money	O Outbursts of anger
O Lying	O Bad temper
O Excessive time spent on videogames or hobbies	O Destroying property when angry
	O Injury to animals
O Excessive time online	o Other ________________________________

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 Yes, please list:

Name of therapist: ______________________ Dates of treatment: ______________________	Reason for seeking help:
Name of therapist: ______________________ Dates of treatment: ______________________	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. Include herbs, vitamins and supplements. Use the back if necessary

Medication	**Dosage**	**How long have you been taking it?**	**Has it been helpful?**

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**

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(Continue on back if needed)			

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

Hospital	Dates	Reason

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

___

___

___

MEDICAL HISTORY: Do you now, or have you ever had, any of the following conditions? Please check all that apply. Include date of onset:

O Hypothyroid	O Multiple sclerosis	O Head injury or concussion	O Heart attack	O Stomachache
O Hyperthyroid	O Other muscle problem	O Strep throat	O Mitral valve prolapse	O Poor appetite
O Cancer	O Exercise intolerance	O Seasonal Allergy	O Other heart problem	O Eat too much
O Type II Diabetes	O Exercise comes last (too busy)	O Asthma	O High blood pressure	O Eat too little
O Type I Diabetes	O Dislike of exercise	O Headaches	O High cholesterol or triglycerides	O Food allergy
O Rheumatoid arthritis	O Arthritis	O Migraines	O Poor sleep	O Yeast/Candida overgrowth
O Lupus	O Backaches	O Dizziness	O Sleep too much	O Celiac disease
O Alopecia	O Neck/shoulder pain	O Tinnitus	O Sleep too little	O Gluten intolerance
O Autoimmune disease	O Acne	O Ear infections	O Sleep apnea	O Leaky Gut
O Underweight	O Eczema	O Sinusitis or bronchitis	O Fatigue	O Acid Reflux or GERD
O Overweight	O Psoriasis	O Eye problems	O Birth control pills	O Parasites
O Toxic mold problem	O Other skin problem	O Frequent need for antibiotics	O Athlete's foot	O IBS or Crohn's Disease
O Menopause	O Hormone replacement	O Other:	O Other:	O Other:

Of the conditions above, if you are currently undergoing treatment please describe:

Condition	Date treatment began	Treatment Provider	What is the treatment?	Is it helping?

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(continue on back if needed)

List any serious illnesses, operations or accidents:

Condition	Date	Physician	What is the treatment	Is it helping?

Any other health problems?

___

___

GENDER IDENTITY:

Do you consider yourself to be

- O Heterosexual or straight
- O Mostly heterosexual or straight
- O Bisexual or pansexual
- O Prefer not to answer
- O Mostly gay or lesbian
- O Gay or lesbian
- O Questioning
- O Other: ___

RELIGIOUS CONCERNS

During your childhood, what was the religious affiliation of your family?___

What is your present religious affiliation?

- O Catholic
- O Protestant: ___
- O Mormon
- O Muslim
- O Jewish
- O B'nai
- O Hindu
- O Buddhist
- O Atheist or agnostic
- O None, but I believe in God
- O Other ___

How important is religious commitment to you?

Not important at all			Average			Extremely Important
1	2	3	4	5	6	7

Do you desire to have your religious beliefs and values incorporated into the counseling process?

Yes No Not sure (If Yes, please explain) ___ ___

___

Do you desire to have particular attention to specific cultural or ethnic values during the counseling process? Yes No Not sure (If Yes, please explain) ___

___

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Intake Questionnaire for New Patients (Adult) – Part 2

Name: ______________________________ Today's Date: ___________________________________

FAMILY HISTORY

Father: If living, current age: _____________ If deceased, cause of death: _______________________
If deceased, his age at time of his death _____ Your age at time of his death: ____________________
His country of birth: ________________________ If not U.S., year of immigration: __________________
His occupation: ___________________________ His health: ___________________________________
Frequency of contact with him: _______________ Are you/Have you been close to him? No Yes
Describe your father's (or father substitute's) personality and his attitude toward you (past and present):

____
____
____

Mother: If living, current age: ______________ If deceased, cause of death: ________________________
If deceased, her age at time of her death ______ Your age at time of her death: ______________________
His country of birth: ________________________ If not U.S., year of immigration: __________________
Her occupation: __________________________ Her health: _____________________________________
Frequency of contact with her: _______________ Are you/Have you been close to her? No Yes
Describe your mother's (or mother substitute's) personality and her attitude toward you (past and present):

____
____
____

Brothers and Sisters

Name	Gender	Age	Whereabouts	Are you close to him/her?			
					No		Yes
					No		Yes
					No		Yes
					No		Yes

Any significant details about siblings?

____
____

During your childhood, did you live any significant period of time with anyone other than your natural parents? No Yes

If yes, please give the person's name and relationship to you

Name: _____________________________ Relationship to you: __________________________

Between what years did you live with this person? ____________________________________

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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	Grandparent
Nervous Problems							
Depression							
Hyperactivity							
Socially withdrawn/shy							
Learning problems							
Counseling							
Psychiatric Medication							
Psychiatric Hospitalization							
Suicide Attempt							
Death by Suicide							
Drinking Problem							

SOCIAL HISTORY

Past Marital History

Have you been married previously? No Yes If Yes, please describe: ________________________

When?__________________ Where?________________ How long? ________________________________

When?__________________ Where?________________ How long? ________________________________

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 ____

Have you been arrested? No Yes If yes, please describe: ______________________________________

____

Do you have any current pending legal issues, or do you anticipate any (divorce, custody, etc)?
No Yes If yes please describe: ____

Education

Highest grade level completed:_____________________

Degree obtained, if applicable: _________________Major: ____

Did you have any disciplinary problems in school? ________________

If yes, please explain: ____

Were you considered to be hyperactive, inattentive or have ADHD when you were in school? No Yes

If yes, did you take any medication? No Yes If yes, which medication?___________________________

What kinds of grades did you get in school? ____

Have you served in the military? No Yes If yes, please describe briefly:

____

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

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Employment History (most recent first)

Type of Job	Dates	Reason for Leaving

SUBSTANCE ABUSE

Alcohol

Do you drink alcohol? No Yes If Yes, age of first use _____

How much do you drink? _______________ per week How often do you drink? ____________________

Please place a check mark in the appropriate box according to your experiences:	Never	Sometimes	Often	Almost Always
Have you ever passed out from drinking				
Have you ever blacked out from drinking?				
Have you ever had the "shakes"?				
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 first use	Time since last use	Approx use in last 30
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				
Other drugs:				

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STRENGTHS:

Hobbies and interests: ____

____

How do you usually spend your free time? ____

____

What are your 5 greatest strengths?

1. ____
2. ____
3. ____
4. ____
5. ____

What is one of your greatest accomplishments so far? ____

____

GOALS:

In what area(s) do you have the most difficulty?

- O Social difficulties
- O Love and sex difficulties
- O Difficulties at school or work
- O Difficulties at home
- O Other: ____

Some behaviors you would like to do less often:

1. ______________________________
2. ______________________________
3. ______________________________

Some behaviors you would like to do more often:

1. ______________________________
2. ______________________________
3. ______________________________

ADDITIONAL REMARKS: Please tell me anything else you would like me to know.

____

____

____

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SELF-CARE:

How frequently do you engage in the following self-care activities? How important are they to you?

Activity	How Often or How Many Hours every week	How important is this to you? 4 = Already part of my daily/weekly routine 3 = One of my goals 2 = Would like it to be a goal, but not a priority right now 1 = Little or no interest or importance to me
Exercise – what type of exercise do you do?		1 2 3 4
Time spent on good nutrition. What do you do?		1 2 3 4
Time spent with others who are a positive influence		1 2 3 4
Time spent meditating or in prayer or in spiritual growth that is meaningful to you		1 2 3 4
Time spent volunteering, helping others outside immediate family, or otherwise contributing to the community. What do you do?		1 2 3 4
Time spent on hobbies, sports, doing something creative, or other interest just for fun. What do you enjoy doing?		1 2 3 4
Do you ever do something that engages you so deeply that you lose track of time? What do you do? Is this a positive experience? No Yes		1 2 3 4
Other. Please specify:		1 2 3 4

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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	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	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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