Center for Family Development

Adult Intake Questionnaires

In order for me to be able to fully evaluate you, please fill out the following intake form and questionnaires to the best of your ability. I realize there is a lot of information and you may not remember or have access to all of it; do the best you can. If there is information you do not want in your medical chart it is ok to refrain from putting it in this information. Thank you!

PATIENT IDENTIFICATION

First Name ____________________ Middle Initial: _____ Last Name: ____________________

Nickname: ______________________ First Appointment Date __________________

Birth Date ______________ Age ______ Sex _____ Race ____ Marital Status ______

Religion ____________________ Social Security No. __________________________

Address ____

City ____________________ State ____ Zip _____________

Home Phone: ____________________ Work Phone: _______________

Cell: ____________________ Email: ____________________________

Children: Name Date of Birth relationship to patient Problems Strengths

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Who are you currently living with? ____

Person to contact in case of emergency: ____________________________ Phone: ____________________

Who referred you to us? ________________________

Do I have your permission to release information to the referring professional when it is appropriate?

Yes ____ No _____

Main Purpose of the consultation (Please give a brief summary of the main problems)

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What happened to make you seek evaluation at this time?

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MEDICAL HISTORY Current medical **Prior Attempts to correct the problem/Prior psychiatric history:** (Please include contact with other professionals, medications, types of treatment, etc.)

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problems/medications: ____

____

Current supplements/vitamins/herbs: ____

Past medical problems/medications: ____

____

Other doctors/clinics seen regularly: ____

Any history of hitting your head, even if you don't lose consciousness? (e.g. car accident, hitting head on monkey bars, playing football, etc):

____

____

Have you ever lost consciousness? ____

Have you been exposed to toxic substances? (e.g. furniture refinishing, agent orange, pesticides, etc)
____

Ever had any seizures or seizure like activity? ____

Prior hospitalizations (place, cause, date, outcome): ____

Prior abnormal lab tests, X-rays, EEG, etc: ____

Allergies/drug intolerances (describe): ____

Do you have mold in your house? ____

Do you have a carbon monoxide detector in your house? Yes No

Do you have silver amalgam dental fillings? Yes No Present Height _______ Present Weight _______

Current Life Stresses: (include anything that is currently stressful for you, examples include relationships, job, school, finances, children)____

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____

Prenatal and birth events: Your parents' attitudes toward their pregnancy with you _____________________

Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use,

etc____Any

birth problems, trauma, forceps or complications?______________________________________

Sleep behavior:

Is it hard for you to make yourself go to bed? Yes No Explain: ____________________________________ How

long does it take you to fall asleep? ______________

Do you stay asleep? Yes No Explain: ____

Do you snore? Yes No Do you have sleepwalking, nightmares, night terrors, recurrent dreams, restless legs, talking in your sleep?
____

____

School History: Last grade completed _______________ Last school attended ____________________________

Average grades received ________________ Specific learning disabilities _________________________________

Learning strengths ____

Any behavior problems in school? ____

What have teachers said about you?____

Employment History: (summarize jobs you've had, list most favorite and least favorite)

____

____

____

Any work-related problems? ____

What would your employers or supervisors say about you? ____________________________________

____

Military History? ____

____

Ever Any Legal Problems? ____

____

Alcohol and Drug History: (Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel; what benefit you got from them.). These include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms, PCP).

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Do you or have you ever experienced withdrawal symptoms from alcohol or drugs?________________________

Has anyone told you they thought you had a problem with drugs or alcohol?______________________________

Have you ever felt guilty about your drug or alcohol use? ____

Have you ever felt annoyed when someone talked to you about your drug or alcohol use? ___________________

Have you ever used drugs or alcohol first thing in the morning?____

Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate) _______________________________________

Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew) _____________________
____

Sexual history: (answer only as much as you feel comfortable) Primary Sexual Orientation: Gay, Straight,

Bisexual Age at the time of first sexual experience: _______ Number of sexual partners: _________

Any history of sexually transmitted disease? _________ History of abortion? ____________________________

History of sexual abuse, molestation or rape? ____

Current sexual problems?____

Any history of being physically or sexually abused? Yes No

____

FAMILY HISTORY Family Structure (who lives in your current household, please give relationship to each):

____

____

____

Current Marital or Relationship Satisfaction____

____

____

Significant Life Events (include past and current marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.)
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_

Natural Mother's History: age_____ occupation ____

School: highest grade completed ______________

Learning problems ____

Behavior problems ____

Marriages ____

Medical Problems ____

Childhood atmosphere (family position, abuse, illnesses, etc)____

____

Has mother ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _________________

____

Mother's alcohol/drug use history

____

____

Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

____ _

____

Natural Father's History: age_____ occupation ____

School: highest grade completed _____________

Learning problems ____

Behavior problems ____

Marriages ____

Medical Problems ____

Childhood atmosphere (family position, abuse, illnesses, etc) _______________________________________

____

Has father ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? __________________

____

Father's alcohol/drug use history: ____

____

Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

____

____

Siblings: Name Age relationship to patient Problems Strengths

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____

____

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____

____

Cultural/Ethnic Background: ____

____

Describe your relationships with friends: ____

____

Describe yourself: ____

____

Describe your strengths:

____

____

What would you like to accomplish in your meeting?

____

____

Primary Insurance Information:

Insurance Company name: ____

Policy Number or Contract #: _________________________________ Group #: ________________

Social Security number of Policyholder: ______________________________

Employer Name: _____________________________ Name of Policyholder: _______________________
Birth Date of Policyholder: _________________ Address of policyholder: _________________________

City: _____________________ State: __________ Zip: ____________ Phone: ____________________

Secondary Insurance Information:

Insurance Company name: ____

Policy Number or Contract #: _________________________________ Group #: ________________

Social Security number of Policyholder: ______________________________

Employer Name: _____________________________ Name of Policyholder: _______________________

Birth Date of Policyholder: _________________ Address of policyholder: _________________________

City: _____________________ State: __________ Zip: ____________ Phone: ____________________

I understand as the primary responsible party, I will pay for all portions of charges that my insurance Company does not cover. I authorize the Center for Family Development to electronically transmit the claim to the insurance company, send any necessary documentation and discuss this case including diagnosis and other information from the clinical record with the insurance companies listed. I authorize my insurance company to send benefits directly to the Center for Family Development.

In case of canceled appointments, I agree to provide **24 hours** notice to the Center for Family Development or be responsible for a $30.00 missed appointment fee.

Signature of Responsible Party: _________________________________ Date: __________________

Amen Brain System Checklist

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (such as a spouse, partner or parent) rate you as well. List other ____________________

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable/Not Known

Other Self

____ ___ 1. Failing to give close attention to details or making careless mistakes
____ ___ 2. Having trouble sustaining attention in routine situations (e.g., homework, chores, paperwork)
____ ___ 3. Having trouble listening
____ ___ 4. Failing to finish things
____ ___ 5. Having poor organization for time or space (such as a backpack, room, desk, paperwork)
____ ___ 6. Avoiding, disliking, or being reluctant to engage in tasks that require sustained mental effort
____ ___ 7. Losing things
____ ___ 8. Being easily distracted
____ ___ 9. Being forgetful
____ ___10. Having poor planning skills
____ ___11. Lacking clear goals or forward thinking
____ ___12. Having difficulty expressing feelings
____ ___13. Having difficulty expressing empathy for others
____ ___14. Experiencing excessive daydreaming
____ ___15. Feeling bored
____ ___16. Feeling apathetic or unmotivated
____ ___17. Feeling tired, sluggish or slow moving
____ ___18. Feeling spacey or "in a fog"
____ ___19. Feeling fidgety, restless or trouble sitting still
____ ___20. Having difficulty remaining seated in situations where remaining seated is expected
____ ___21. Running about or climbing excessively in situations in which it is inappropriate
____ ___22. Having difficulty playing quietly
____ ___23. Being always "on the go" or acting as if "driven by a motor"
____ ___24. Talking excessively
____ ___25. Blurting out answers before questions have been completed
____ ___26. Having difficulty waiting for turn
____ ___27. Interrupting or intruding on others (e.g., butting into conversations or games)
____ ___28. Behaving impulsively (saying or doing things without thinking first)
____ ___29. Worrying excessively or senselessly
____ ___30. Getting upset when things do not go your way
____ ___31. Getting upset when things are out of place
____ ___32. Tending to be oppositional or argumentative
____ ___33. Tending to have repetitive negative thoughts
____ ___34. Tending toward compulsive behaviors (i.e., things you feel you *must* do)
____ ___35. Intensely disliking change
____ ___36. Tending to hold grudges
____ ___37. Having trouble shifting attention from subject to subject
____ ___38. Having trouble shifting behavior from task to task
____ ___39. Having difficulties seeing options in situations
____ ___40. Tending to hold on to own opinion and not listen to others
____ ___41. Tending to get locked into a course of action, whether or not it is good
____ ___42. Needing to have things done a certain way or else becoming very upset
____ ___43. Others complaining that you worry too much
____ ___44. Tending to say no without first thinking about the question
____ ___45. Tending to predict fear
____ ___46. Experiencing frequent feelings of sadness
____ ___47. Having feelings of moodiness
____ ___48. Having feelings of negativity

____ ___49. Having low energy
____ ___50. Being irritable
____ ___51. Having a decreased interest in other people
____ ___52. Having a decreased interest in things that are usually fun or pleasurable
____ ___53. Having feelings of hopelessness about the future
____ ___54. Having feelings of helplessness or powerlessness
____ ___55. Feeling dissatisfied or bored
____ ___56. Feeling excessive guilt
____ ___57. Having suicidal feelings
____ ___58. Having crying spells
____ ___59. Having lowered interest in things that are usually considered fun
____ ___60. Experiencing sleep changes (too much or too little)
____ ___61. Experiencing appetite changes (too much or too little)
____ ___62. Having chronic low self-esteem
____ ___63. Having a negative sensitivity to smells/odors
____ ___64. Frequently feeling nervous or anxious
____ ___65. Experiencing panic attacks
____ ___66. Symptoms of heightened muscle tension (such as headaches, sore muscles, hand tremors, etc.)
____ ___67. Experiencing periods of a pounding heart, a rapid heart rate, or chest pain
____ ___68. Experiencing periods of troubled breathing or feeling smothered
____ ___69. Experiencing periods of dizziness, faintness, or feeling unsteady on your feet
____ ___70. Feeling nausea or having an upset stomach
____ ___71. Experiencing periods of sweating, hot flashes, or cold flashes
____ ___72. Tending to predict the worst
____ ___73. Having a fear of dying or doing something crazy
____ ___74. Avoiding places for fear of having an anxiety attack
____ ___75. Avoiding conflict
____ ___76. Excessively fearing being judged or scrutinized by others
____ ___77. Having persistent phobias
____ ___78. Having low motivation
____ ___79. Having excessive motivation
____ ___80. Experiencing tics (either motor or vocal)
____ ___81. Having poor handwriting
____ ___82. Being quick to startle
____ ___83. Having a tendency to freeze in anxiety-provoking situations
____ ___84. Lacking confidence in own abilities
____ ___85. Feeling shy or timid
____ ___86. Being easily embarrassed
____ ___87. Being sensitive to criticism
____ ___88. Biting fingernails or picking at skin
____ ___89. Having a short fuse or experiencing periods of extreme irritability
____ ___90. Having periods of rage with little provocation
____ ___91. Often misinterpreting comments as negative when they are not
____ ___92. Finding that own irritability tends to build, then explodes, then recedes, often being tired after a rage
____ ___93. Having periods of spaciness and/or confusion
____ ___94. Experiencing periods of panic and/or fear for no specific reason
____ ___95. Experiencing visual and/or auditory changes, such as seeing shadows or hearing muffled sounds
____ ___96. Having frequent periods of *deja vu* (that is, feelings of being somewhere you have never been)
____ ___97. Being sensitive or mildly paranoid
____ ___98. Experiencing headaches or abdominal pain of uncertain origin
____ ___99. Having a history of a head injury or family history of violence or explosiveness
____ ___100. Having dark thoughts, ones that may involve suicidal or homicidal thoughts
____ ___101. Experiencing periods of forgetfulness or memory problems

Medical Review of Systems

Please place a check mark in the boxes that apply. Explain any problem areas.

General
- ❑ Being overweight
- ❑ Recent weight gain or weight loss
- ❑ Poor appetite
- ❑ Increased appetite
- ❑ Abnormal sensitivity to cold
- ❑ Cold sweats during the day
- ❑ Tired or worn out
- ❑ Hot or cold spells
- ❑ Abnormal sensitivity to heat
- ❑ Excessive sleeping
- ❑ Difficulty sleeping
- ❑ Lowered resistance to infection
- ❑ Flu-like or vague sick feeling
- ❑ Sweating excessively at night
- ❑ Urinating excessively
- ❑ Excessive daytime sweating
- ❑ Excessive thirst
- ❑ Other______________________

Neurological
- ❑ Pacing due to muscle restlessness
- ❑ Forgotten periods of time
- ❑ Dizziness
- ❑ Drowsiness
- ❑ Muscle spasms or tremors
- ❑ Impaired ability to remember
- ❑ "Tics"
- ❑ Numbness
- ❑ Convulsions / fits
- ❑ Slurred speech
- ❑ Speech problem (other)
- ❑ Weakness in muscles
- ❑ Other______________________

Respiratory
- ❑ Asthma, wheezing
- ❑ Cough
- ❑ Coughing up blood or sputum
- ❑ Shortness of breath
- ❑ Rapid breathing
- ❑ Repeated nose or chest colds
- ❑ Other______________________

Chest and Cardiovascular
- ❑ Ankle swelling
- ❑ Rapid / irregular pulse
- ❑ Breast tenderness
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Other______________________

Head, Eye, Ear, Nose, & Throat
- ❑ Facial pain
- ❑ Headache
- ❑ Head injury
- ❑ Neck pain or stiffness
- ❑ Frequent sore throat
- ❑ Blurred vision
- ❑ Double vision
- ❑ Overly sensitive to light
- ❑ See spots or shadows
- ❑ Hearing loss in both ears
- ❑ Ear ringing
- ❑ Disturbances in smell
- ❑ Runny nose
- ❑ Dry mouth
- ❑ Sore tongue
- ❑ Other______________________

Gastrointestinal and Hepatic
- ❑ Trouble swallowing
- ❑ Nausea or vomiting (throwing up)
- ❑ Abdominal (stomach / belly) pain
- ❑ Anal itching
- ❑ Painful bowel movements
- ❑ Infrequent bowel movements
- ❑ Liquid bowel movements
- ❑ Loss of bowel control
- ❑ Frequent belching or gas
- ❑ Vomiting blood
- ❑ Rectal bleeding (red or black blood)
- ❑ Jaundice (yellowing of skin)
- ❑ Other______________________

Musculoskeletal
- ❑ Back pain or stiffness
- ❑ Bone pain
- ❑ Joint pain or stiffness
- ❑ Leg pain
- ❑ Muscle cramps or pain
- ❑ Other______________________

Skin, Hair
- ❑ Dry hair or skin
- ❑ Itchy skin or scalp
- ❑ Easy bruising
- ❑ Hair loss
- ❑ Increased perspiration
- ❑ Sun sensitivity
- ❑ Other______________________

Genitourinary
- ❑ Itchy privates or genitals
- ❑ Painful urination
- ❑ Excessive urination
- ❑ Difficulty in starting urine
- ❑ Accidental wetting of self
- ❑ Pus or blood in urine
- ❑ Decreased sexual desire
- ❑ Other______________________

Females
- ❑ No menses
- ❑ Menstrual irregularity
- ❑ Painful or heavy periods
- ❑ Premenstrual moodiness, irritability, anger, tension, bloating, breast tenderness, cramps, headache
- ❑ Painful menstrual periods
- ❑ Painful intercourse or sex
- ❑ Sterility infertility
- ❑ Abnormal vaginal discharge

Other______________________

Males
- ❑ Impotence (weak male erection)
- ❑ Inability to ejaculate or orgasm
- ❑ Scrotal pain
- ❑ Abnormal penis discharge

Other______________________

Explanation

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