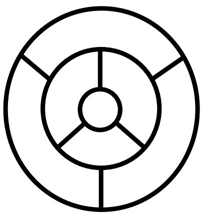

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General Intake Questionnaire

In order to gain an understanding of your problems, I am asking you to complete the following information about yourself. This includes information about your present symptoms, your previous health, your family and personal background, and recent stressors and changes in your life. This will be very helpful in providing the best care for you. Your cooperation is appreciated.

Name gender:

Address ethnic heritage:

City State Zip

Birth date Religion Marital Status Partner's Name

Phone(s): Home Cell e-mail

Employer Work Phone shift worker? Y N

May I leave a message for you at home? **Y** **N** at work? **Y** **N**

What is the best time and number to call you at?

FAMILY CONSTELLATION: Please fill in the following information about your family

	living?	age now or age at death	if dead, year and age
Father	YES NO		
Mother	YES NO		
Spouse	YES NO		

Sons No. living Ages

No. dead year and age

Daughters No. living Ages

No. dead year and age

Blood kinfolk have had the following (circle all that apply)

insomnia sleepwalking alcoholism drug abuse suicide depression anxiety

GOALS: What do you hope to accomplish in treatment?

MEDICAL INFORMATION

Personal Physician: phone fax

Current medications:

Perceived Stress Scale

IN THE LAST MONTH HOW OFTEN HAVE YOU …	None of the time	Rarely	Some of the time	Often	All of the Time
Been upset because of something that happened unexpectedly?	0	1	2	3	4
Felt that you were unable to control the important things in your life?	0	1	2	3	4
Felt nervous and stressed?	0	1	2	3	4
Felt confident about your ability to handle your personal problems?	4	3	2	1	0
Felt that things were going your way?	4	3	2	1	0
Found that you could not cope with all the things that you had to do?	0	1	2	3	4
Been able to control irritations in your life?	4	3	2	1	0
Felt that you were on top of things?	4	3	2	1	0
Been angered because of things that were outside your control?	0	1	2	3	4
Felt difficulties were piling up so high that you could not overcome them?	0	1	2	3	4

Symptom Rating Scale

During the past **TWO (2) WEEKS how much (or how often) have you been bothered by the following problems?**	**None** Not at all	**Slight** Rare, less Than a day Or two	**Mild** Several days	**Moderate** More than Half the days	**Severe** Nearly Every Day
Little interest or pleasure in doing things?	0	1	2	3	4
Feeling down, depressed, or hopeless?	0	1	2	3	4
Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4
Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4
Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4
Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4
Feeling panic or being frightened?	0	1	2	3	4
Avoiding situations that make you nervous?	0	1	2	3	4
Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4
Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4
Thoughts of actually hurting yourself?	0	1	2	3	4
Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4
Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4
Problems with sleep that affected your sleep quality overall?	0	1	2	3	4
Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4
Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4
Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4
Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4
Not knowing who you really are or what you want in life?	0	1	2	3	4
Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4
Drinking at least 4 drinks of any kind or alcohol in a single day?	0	1	2	3	4
Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4
Using any of the following medicines ON YOUR OWN, that is without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue) or methamphetamine (like speed)]?	0	1	2	3	4