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New Client Intake Questionnaire

1. Identifying information:

First Name:_____Middle Initial:____Last Name:_____
Date of Birth:_____Sex:_____Marital Status:_____
Street Address:_____
City:_____State:_____Zip:_____
Social Security Number:_____
Email Address:_____Okay to use? ☐ Yes ☐ No

Telephone numbers: *Mark the number you would prefer to use.*

☐ Mobile: _____Okay to use? ☐ Yes ☐ No
☐ Home: _____Okay to use? ☐ Yes ☐ No
☐ Work: _____Okay to use? ☐ Yes ☐ No

Person Financially Responsible for Client: ☐ Self ☐ Other
If Other: First Name:_____Last Name:_____
Relationship to Client:_____Health Care Proxy? ☐ Yes ☐ No
Street Address:_____
City:_____State:_____Zip:_____
Preferred Contact Phone Number:_____

Emergency Contact:

First Name:_____Middle Initial:____Last Name:_____
Relationship to Client:_____Health Care Proxy? ☐ Yes ☐ No
Street Address:_____
City:_____State:_____Zip:_____
Telephone: *Please provide two numbers for emergency contact.*
Mobile: _____
Home: _____
Work: _____

2. Current Medications. *Including over the counter drugs, vitamins, herbal and nutritional supplements, hormone-based contraceptives.*

3. Allergies: *list both the allergen and the reaction to it.*

4. Milestones. Mark and briefly describe if any of the following events occurred in the last 12 months.

☐ Became engaged: _____
☐ Got married: _____
☐ Separated: _____
☐ In middle of / completed divorce: _____
☐ Ended significant relationship: _____
☐ Trying to conceive: _____
☐ You or significant other pregnant: _____
☐ Joined by new family member: _____
☐ Child left or returned home: _____
☐ Behavior problems with family member: _____
☐ Caring for ill family member: _____
☐ Death of family member: _____
☐ Difficulties at school or work: _____
☐ Ended employment: _____
☐ Financial problems: _____
☐ Changed residence: _____
☐ Legal problems: _____

5. Review of Systems.

In each area, if you experienced any of the symptoms listed in the past 90 days, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. Check "no problems" if you have had no difficulties. If you have any questions, please ask me at our initial consultation.

General Health ❑ No Problems Lack of energy, unexplained weight gain or loss > 10 lbs over 3 months, loss of appetite, fever, night sweats, Other: _____

Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

Cardiovascular (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Respiratory. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

Gastrointestinal (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, change in bowel habits, incontinence. Other: _____

Genito-Urinary (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

Musculoskeletal ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Skin and Hair ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, unexplained swollen areas. Other: _____

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

6. Medical History.

Active Medical Problems:		Prior Surgeries:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you snore loudly *(louder than talking, or loud enough to be heard behind closed doors)*? ☐ Yes ☐ No
Do you often feel tired, fatigued, or sleepy during the day? ☐ Yes ☐ No
Has anyone observed you stop breathing during sleep? ☐ Yes ☐ No
Do you have or are you treated for high blood pressure? ☐ Yes ☐ No

In your lifetime, any history of the following (explain any 'yes' answer)
Fainting spells? ☐ Yes ☐ No
Blackouts? ☐ Yes ☐ No
Seizures? ☐ Yes ☐ No
Head injury? ☐ Yes ☐ No
Chest Pain? ☐ Yes ☐ No
Heart Palpitations? ☐ Yes ☐ No
Shortness of breath? ☐ Yes ☐ No

7. Women's Health.

Have you reached menopause? ☐ Yes ☐ No Last period:_____
Are your cycles regular? ☐ Yes ☐ No Explain. _____
Do your thoughts or emotions change with your cycle? ☐ Yes ☐ No
(if Yes) Explain._____
Are you using a hormone-releasing form of contraception? ☐ Yes ☐ No
(if Yes) Name: _____ Duration of use: _____
Any change in your thoughts or emotions since starting your contraceptive? Explain._____

8. Clinical Support Network.

Primary Care Physician: ☐ I do not have a primary care physician currently

Name:_____ Clinic Name:_____

Office Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

Frequency of visits:_____ Month/Year of last visit:_____

Therapist: ☐ I do not have a therapist currently

Name:_____ Clinic Name:_____

Office Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

Frequency of visits:_____ Month/Year of last visit:_____

Current / Former Psychiatrist: ☐ I have never had a psychiatrist

Name:_____ Clinic Name:_____

Office Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

Frequency of visits:_____ Month/Year of last visit:_____

If Former: Reasons for ending treatment:_____

If current: I am requesting this consultation because:

☐ I would like a second opinion.

☐ I am in the process of terminating with my current psychiatrist.

☐ I need an independent evaluation required by some 3rd party.

☐ Other:_____