Sunrise Family Clinic

Psychiatric Intake Questionnaire

Thank you for taking the time to complete this form! All information on this form is strictly confidential.

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Name: _____ Preferred Name: _____

Please provide a brief summary of the problem(s) you are seeking help for:

_____

_____

_____

Are you involved in any kind of legal matter or investigation? If so, please describe.

_____

_____

Current Life Stresses (work, school, relationship, finances, etc.):

_____

_____

Past Psychiatric History:

Do you have a current psychologist/therapist/counselor? ( )Yes ( ) No

If so, please provide their name and phone #: _____

Do you provide your consent for me to speak with this provider when necessary to best support you? ( ) Yes ( ) No

Please list any counseling/therapy you have done at any time in your life:

Type (if known)	How long?	Response

Have you ever seen a psychiatrist or psychiatric nurse practitioner? ( ) Yes ( ) No

Reason Dates treated Name

_____

_____

_____

Have you ever been hospitalized in a psychiatric facility? ( ) Yes ( ) No

Reason Date Hospitalized Where

_____

_____

_____

Psychiatric Medications:

Please list **ALL** medications you are ***currently* taking *or have ever taken*** for depression, anxiety, mood problems, sleep or other mental health issues. (If you can't remember all the details just write in what you do remember)

Medication	Dose	How long?	Response	Side Effects

Medical History:
Allergies (to medications or foods):_____

Please list ALL current *non-psychiatric* medications: (if none, write none)

Medication Name Total Daily Dosage

_____
_____
_____
_____
_____

Current over-the-counter medications or supplements and dosage:

_____
_____

What medical problems do you have/have you had in the past? (Examples: diabetes, high blood pressure, high cholesterol, thyroid problems, anemia, asthma, GERD)

_____
_____
_____

Have you had any surgeries? ( ) Yes ( ) No
If yes, please list type and year:

_____
_____

Have you been medically hospitalized? ( ) Yes ( ) No
If yes, please give the reason and the approximate year.

Reason for Hospitalization Year Hospitalized

_____
_____
_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth including substance use?
( ) Yes ( ) No ( ) Unknown
If yes, please describe:

_____

Have you ever had a head injury? ( ) Yes ( ) No
If yes, please describe:

_____

Any history of seizures? ( ) Yes ( ) No
If yes: when was the most recent one?_____
Have you ever had an EKG? ( ) Yes ( ) No ( ) Unsure
If yes: when was the most recent one?_____
What was the doctor's name? _____
Was the EKG ( ) normal ( ) abnormal or ( ) unknown

For females only: Date of last menstrual period (or note if post-menopausal or if you have had a hysterectomy) _____
Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No
Are you hoping to become pregnant in the near future? ( ) Yes ( ) No

Lifestyle:
Do you exercise three or more times per week? ( ) Yes ( ) No
If yes, please describe_____

How many hours per night do you sleep on average? ( ) < 6 ( ) 6-8 ( ) 8-10 ( ) 10 +

Check which apply to you: ( ) Trouble falling asleep ( ) Wake up during the night ( ) Don't feel rested

How do you handle stress? What helps you relax? _____
_____

How many caffeinated beverages do you drink a day on average?
Coffee _____ Sodas _____ Tea _____

Do you have or have you ever had an struggles around eating or been diagnosed with or thought you might have an eating disorder? ( ) Yes ( ) No Please explain _____
_____

How many servings of fruits/vegetables do you have in a day? _____ What kinds? _____
_____

How many sugary foods or drinks with sugar do you consume on an average day? _____

Relationship History and Current Family:
Are you currently: ( ) Married ( ) Divorced ( ) Single ( ) Widowed ( ) In a relationship
If currently partnered, how long? _____
Spouse/partner's name: _____
Are you sexually active? ( ) Yes ( ) No
Current form of birth control/disease prevention: _____
If currently partnered, is your current relationship overall physically safe and emotionally supportive?
( ) Yes ( ) No

Do you have children? ( ) Yes ( ) No. If yes, list names and ages (and if living)
_____
_____

Who currently lives in your home with you?_____
_____

Occupational History:
Are you currently: ( ) Employed outside the home ( ) Stay-at-home partner/parent
( ) Unemployed ( ) Disabled ( ) Retired ( ) Student
If ever employed outside the home, what is/was your occupation? _____
Have you ever served in the military? _____

Educational History:
What is your highest educational level or degree attained?_____
Did you/do you have difficulty in school? If so, please explain: _____
_____

Family Background and Childhood History:
Were you adopted? ( ) Yes ( ) No
Where did you grow up? _____
With whom? _____
Was your childhood safe and nurturing? ( ) Yes ( ) No
Are your parents currently living? Mother: ( ) Yes ( ) No Father: ( ) Yes ( ) No
Are you close with your parents? Mother: ( ) Yes ( ) No Father: ( ) Yes ( ) No

Family Psychiatric History:
Has anyone in your family ever been diagnosed with or treated for:

	YES	NO	WHO?		YES	NO	WHO?
Bipolar				Schizophrenia			
Depression				Post-traumatic stress			
Anxiety				Substance abuse			
ADHD				Violence			
Suicide				Other:			

History of Suicidality
Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.
Do you **currently** feel that you don't want to live? ( ) Yes ( ) No
Have you ever tried to kill or harm yourself before? ( ) Yes ( ) No

Nature of Self-Harm Year that Self-Harm Occurred
_____
_____
_____

Substance Use:
Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances? _____
Please describe your treatment: _____
_____

On average, how many days per week do you drink any alcohol? _____

In the past three months:
a) what is the largest amount of alcoholic drinks you have consumed in one day? _____
b) how frequently have you consumed this amount of alcoholic drinks? _____

Check if you have ever tried the following:

	Yes	No	If yes, when did you last use?
Methamphetamine	( )	( )	_____
Cocaine	( )	( )	_____
Stimulants (not as prescribed)	( )	( )	_____
Heroin	( )	( )	_____
LSD or Hallucinogens	( )	( )	_____
Marijuana/Cannabis	( )	( )	_____
Pain killers (not as prescribed)	( )	( )	_____
Methadone	( )	( )	_____
Anxiety meds (not as prescribed)	( )	( )	_____
Ecstasy	( )	( )	_____

Other _____

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No ( ) Possibly

Tobacco History
Have you ever smoked cigarettes/pipe/cigars, or used chewing tobacco? ( ) Yes ( ) No
How many years have you/did you use?_____
Do you smoke or use tobacco currently? **( )** Yes **( )** No If no, when did you quit? _____
How much do you currently use tobacco per day on average? _____

Trauma History:
Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No
If yes, please explain what you feel comfortable sharing. *(It's ok to leave blank)*
_____
_____

Legal: Have you ever been arrested? ( ) Yes ( ) No
If yes, please explain: _____
Do you have any pending legal problems? ( ) Yes ( ) No
If yes, please explain: _____
_____

Spiritual life/Purpose
Do you have a regular religious or spiritual practice? ( ) Yes ( ) No
Is your religion or spirituality an important part of your strategy for coping with mental health concerns? ( ) Yes ( ) No

What things bring you a sense of purpose in your life? _____
_____

What are your strengths? _____
_____
_____

What are your goals for treatment? _____
_____
_____

Is there anything else that you feel is important to share?
_____
_____
_____

****

Patient/Guardian Signature: _____ Date: _____

Relationship to patient: _____

Patient's Guardian Name (if applicable): _____