INTAKE

The purpose of this questionnaire is to obtain a comprehensive picture of your background. In scientific work, records are necessary to permit a more thorough perspective of one's challenges.

By completing these questions as fully and accurately as you can, you will facilitate your therapeutic program. You are requested to answer these routine questions in your own time instead of during your actual consulting time.

PLEASE NOTE: If you do not desire to answer any questions, merely write, "DO NOT CARE TO ANSWER" in the corresponding area. OR, if the question does not apply to you, please write N/A.

Today's Date: _____
Client Name: _____
Gender: M F
Date of Birth: _____ Age: _____ Social Security #: _____
Street Address_____
City_____ State_____ Zip_____
Employer/School: _____
Emergency Contact/Phone number _____
Parent/Guardian (If under 18) _____ Phone _____
Whom may I thank for referring you _____
Reason for Visit:_____

Preferred Method of Contact or Messages:

Cell phone: _____
Home phone: _____
Work Phone: _____
Email: _____
If you live with another person, may I leave a message with him/her OR on your home phone? Y N

EDUCATIONAL LEVEL (Check highest level achieved)

___ No formal education
___ Some grade, middle, or high school
___ Graduated High school
___ GED completed
___ Some college
___ Presently enrolled
___ College Graduate (Associate/ Bachelor)
___ Some graduate school
___ Master's Degree completed
___ Doctoral Degree completed
___ Vocational school
___ Technical college

MILITARY STATUS (Mark all that apply)

___ None ___ Veteran ___Reservist ___ Medical Discharge
___ Active Duty ___ Retired Military ___ War Veteran
___ Disabled Military ___ Honorable Discharge
___ Dishonorable Discharge ___ Other:_____

WITH WHOM DO YOU RESIDE?

Name: _____ Relationship: _____ Age: ___
Name: _____ Relationship: _____ Age: ___
Name: _____ Relationship: _____ Age: ___
Name: _____ Relationship: _____ Age: ___
Name: _____ Relationship: _____ Age: ___

FAMILY MEMBERS NOT LIVING AT HOME

Name: _____ Relationship: _____ Age: ___
Name: _____ Relationship: _____ Age: ___
Name: _____ Relationship: _____ Age: ___
Name: _____ Relationship: _____ Age: ___
Name: _____ Relationship: _____ Age: ___
Name: _____ Relationship: _____ Age: ___
Name: _____ Relationship: _____ Age: ___

FAMILY DATA:

MOTHER:
Living or Deceased? _____

If deceased, your age at the time of her death? _____
If deceased, cause of her death?
_____

If alive, mother's present age: _____
If alive, mother's present occupation, or if retired, her previous occupation:
_____
If alive, your mother's current health:
_____
Describe your mother's personality and her attitude toward you (past and present):
_____
_____
_____
_____

FATHER:
Living or Deceased? _____

If deceased, your age at the time of his death? _____
If deceased, cause of his death?
_____

If alive, father's present age: _____
If alive, father's present occupation, or if retired, his previous occupation:
_____
If alive, your father's current health:
_____

Describe your father's personality and his attitude toward you (past and present):
_____
_____
_____

STEP/SURROGATE/FOSTER PARENTS: If Step parent(s), at what age did your parent(s) re-marry)?

_____
_____
_____
_____

Describe the atmosphere of the home in which you grew up. Comment on the compatibility between the parents and between the parents and the children:

_____
_____
_____
_____
_____
_____
_____

Did your parents understand you? Describe:

_____
_____

Did you feel loved by your parents? Explain:

_____
_____

Please list any family history of drug or alcohol abuse (including treatment history). Please include parents, siblings, aunts, uncles, grandparents or other parental figures.

_____
_____
_____
_____
_____

SIBLINGS

Name: _____ Age: _____ Resides: _____
Name: _____ Age: _____ Resides: _____
Name: _____ Age: _____ Resides: _____
Name: _____ Age: _____ Resides: _____
Name: _____ Age: _____ Resides: _____

Current relationship with siblings:
#1_____
#2_____
#3_____
#4_____
#5_____

Past relationship with siblings:
#1_____
#2_____
#3_____
#4_____
#5_____

DEVELOPMENTAL HISTORY:

Where were you born & raised?

_____

Please check any of the following that applied to you during your childhood:

___ Night terrors ___ Bed-wetting ___ Sleep walking___Thumb-sucking
___Nail Biting ___ Happy Childhood ___ Unhappy Childhood
___ Stuttering

___ OTHER(S) _____

For how long did the above take place? Were any interventions sought?

_____

Did you have a transitional object? What was it?

_____

RELATIONSHIP/MARITAL HISTORY:

Are you currently in a relationship? YES NO

If NO, describe if you have any challenges at this time due to your single status:

_____
_____
_____
_____

If YES, how long have been in your current relationship?

_____

Are you living together? YES NO
How long living together? _____

In what areas are you and your partner compatible?

_____
_____
_____
_____
_____

In what areas are you and your partner incompatible?

_____
_____
_____
_____
_____

Do you have children/step children? If so, please list them below:

Name_____ Sex_____ Age_____ Step/Biological
Name_____ Sex_____ Age_____ Step/Biological
Name_____ Sex_____ Age_____ Step/Biological
Name_____ Sex_____ Age_____ Step/Biological
Name_____ Sex_____ Age_____ Step/Biological

Any relevant details regarding miscarriages or abortions?

_____
_____

Any relevant details about previous relationships or marriages?

_____
_____

Has anyone (parents, friends, relatives, etc) ever interfered in your marriage/relationship, occupations, etc)? Please describe:

_____
_____
_____
_____

Who are the most important people in your life? Why?

_____
_____
_____
_____

Please describe any family history of mental illness, including treatments, medications and challenges:

_____
_____
_____
_____

Please describe any significant births, deaths, or traumas in your life: i.e.) <u>sexual assault</u>, <u>domestic violence</u>, etc:

_____
_____
_____
_____

Describe your most significant support system (friends, family, church, etc)

_____
_____
_____

What are your hobbies and interests?

_____
_____

How is most of your free time occupied?

_____
_____

Have you ever been the victim of being bullied or teased? Describe:

_____
_____

Is it easy for you to meet and keep friends? Explain:

_____
_____
_____

EMPLOYMENT STATUS:

___Full Time ___Part Time ___Retired ___Self-Employed
___Student ___Homemaker ___Disabled ___Unemployed

<u>Past Work History</u>: Brief History of last (5) jobs held and length of time at each:

1) _____
2) _____
3) _____
4) _____
5) _____

Which job did you enjoy best? (Why?)

_____
_____

Which job did you enjoy least? (Why?)

_____
_____

OCCUPATIONAL HISTORY:

What sort of work are you doing now?

_____
_____
_____

Describe how your current work does or does not satisfy you:

_____
_____
_____

LEGAL ISSUES

Have you ever sued a physician or mental health provider? Please describe:

_____
_____
_____

Are you currently involved in any lawsuits or police issues? Please describe:

_____
_____
_____

Have you been involved in any lawsuits/police issues/incarcerated in the past? Please describe:

_____
_____
_____

MEDICAL HISTORY

Who is your Physician? _____ Phone: _____

When was your most recent general medical check up?

_____

General findings:

_____

Comment on your current physical health:

_____
_____
_____
_____

Please list any physical disabilities:

_____
_____
_____

List any significant illness you have or had/past or present:

_____
_____
_____

Describe any accidents or physical trauma and approximate date of occurrence(s):

_____
_____
_____

Please list any previous surgical procedures and the approximate date of the procedures:

_____
_____
_____
_____

Please list any allergies you have:

_____
_____

Please list all medications you take: (include prescription and OTC):

_____
_____
_____
_____

Please list any significant illnesses (past and present)

_____
_____
_____
_____

MENSTRUAL HISTORY (if applicable)

Age of first menses? _____ **Were you informed or was it a shock? _____**
Are you regular? _____ **Duration: _____**
Discomfort? _____ **Date of last period: _____**
Describe how your period affects your moods: _____
Any chance you are pregnant now? _____
History of PMS? _____
Complications from pregnancies? _____
Experiencing menopausal symptoms? _____

EATING DISORDER HISTORY (if applicable)

Describe any history of eating disorders (anorexia, bulimia, binge eating disorder, other); Include past and present treatment:

_____
_____
_____
_____
_____
_____

SUBSTANCE USE HISTORY:

Have you ever been treated for drug/alcohol abuse? Please describe (drug(s) of choice, dates of treatment(s); current status; etc.

_____
_____
_____
_____
_____
_____

SEXUAL HISTORY:

Sexual Preference:

_____ Heterosexual
_____ Homosexual (gay/lesbian)
_____ Bisexual
_____ Asexual
_____ Transsexual
_____ Not sexually active

Parental attitudes toward sexual activity (i.e.) was there discussion in the home? etc:

_____
_____

When and how did you derive your first knowledge of sex?

_____
_____
_____
_____

When did you first become aware of your sexual impulses?

_____
_____
_____

At what age did you begin masturbating? _____

Describe any experiences of anxiety, guilt or shame arising from masturbation:

_____
_____
_____

Describe any relevant details regarding your first or subsequent sexual experience:

_____
_____
_____

If you are homosexual (gay/lesbian), describe the circumstances surrounding when you "came out". If you haven't "come out" yet, explain:

_____
_____
_____

Are you sexually inhibited in any way? Describe:

_____
_____
_____

CLINICAL:

In your own words, please state the nature of your main reason for attending therapy and the duration of the problem(s):

_____
_____
_____
_____
_____
_____
_____

How would you estimate the severity of your problem(s)?

_____ Mildly upsetting
_____ Moderately upsetting
_____ Very Severe
_____ Extremely Severe
_____ Totally Incapacitating

SUICIDAL HISTORY:

Thoughts: YES NO Describe dates. circumstances, etc.

_____
_____

Attempts: YES NO Describe dates, circumstances, hospitalizations, treatments, etc.

_____
_____

********CURRENT SUICIDAL IDEATION?: YES NO**

If YES, Please go to your nearest emergency room and contact Dr. Mendelsohn after you are stabilized.

With whom have you previously consulted about your present problem(s)?

_____Last consulted: _____
_____Last consulted: _____
_____Last consulted: _____
_____Last consulted: _____
_____Last consulted: _____

List your FIVE main FEARS:

1) _____
2) _____
3) _____
4) _____
5) _____

Are you taking any medications for your present problem(s)? If so, please list name of medication, dosage and results.

_____
_____
_____

Describe any negative side effects from taking the above medications:

_____
_____
_____

What about your present <u>behavior(s)</u> would you like to change?

_____
_____
_____

What <u>feelings</u> do you wish to alter (increase or decrease)?

_____
_____
_____

List the benefits/goals you hope to derive from therapy:

_____
_____
_____

Please list any additional information you think would benefit Dr. Mendelsohn in the your care and treatment planning.

_____
_____
_____
_____
_____

THANK YOU FOR TAKING YOUR TIME TO COMPLETE THIS FORM. PLEASE BRING THIS TO YOUR NEXT APPOINTMENT WITH DR. MENDELSOHN OR EMAIL IT TO DRSUSIE@ME.COM