Intake Questionnaire

Contact information

Date:_____

Your Name: _____

Address: _____

Phone: (Home) _____ (Work) _____

(Cell)_____ (Other, please specify) _____

Email:_____

Are you willing to communicate via email, considering that the confidentiality of e-mail communications cannot be guaranteed (see Therapy Agreement for an elaboration of the risks)? Yes No

Please note that Dr. Ramel does not use email for emergencies or any substantial clinical matters.

Emergency Contact: (Name) _____

(Phone) _____ (Relationship) _____

Referred by _____

If referred by a professional, may I thank this person for the referral? Yes No

Social and family information

Age: _____ Gender: _____ Date of birth: _____

Ethnicity (circle one): Caucasian African American Hispanic Asian

Other: _____

Religious background: Protestant Catholic Jewish Muslim Buddhist No affiliation

(circle one) Other: _____

Marital status: Single, never married Married Separated Divorced

(circle one) Widowed Cohabiting

If you divorced, when did you divorce your previous partner? _____

How long were you married? _____

If you are widowed, when did your spouse die? _____

Names of persons living in your home and your relationship to them:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If you have a partner or spouse, how long have you been together? _____

Spouse/partner's occupation, if applicable:_____

Please list names and ages of your children, if applicable:

Name	Age	Biological?	Name	Age	Biological?
_____		Y / N	_____		Y / N
_____		Y / N	_____		Y / N

Family of origin

Mother's name: _____

If deceased, year and cause of death: _____

If living, age and health status: _____

If living, where does she live now? _____

Her occupation (past and/or present): _____

Father's name: _____

If deceased, year and cause of death:_____

If living, age and health status: _____

If living, where does he live now? _____

His occupation (past and/or present): _____

Siblings:

Name	Age	Occupation	Where does s/he live?

Where did you grow up?_____

Were your parents ever separated? Yes No (circle one) If yes, when?_____

Did your parents get divorced? Yes No If yes, when? _____

Did they remarry? Yes No If yes, when? _____

At what age did you move out of your parents' home? _____

If you were physically disciplined as a child, were you ever injured as a result? Yes No

Did your parent or a person taking care of you ever purposefully injure you in other circumstances (that is, when you were not being disciplined)? Yes No

Do any biological relatives have any history of psychiatric or emotional problems? Yes No

If yes, which family members and what types of problems?

_____

_____

Education/Work

Occupation: _____

Are you working now? No Yes If yes, circle one: Full-time Part-time

Are you going to school now? No Yes If yes, circle one: Full-time Part-time

Number of years of education completed: _____

What is the highest degree you earned in school? _____ When? _____

Did you ever leave a school you were enrolled in prior to completion? Yes No

If yes, give details: _____

Did you ever receive any special education services (e.g. academic tutoring, IEP, classroom accommodations, etc.)?

Yes No If yes, give details: _____

_____

Please provide some general information on your work history:

Type of job held How long?

_____

_____

_____

Presenting complaint

Please describe, briefly, the problem(s) that bring you in to see me.

What are the symptoms, how intense are they, and how often do they occur?

_____

_____

_____

_____

Have there ever been problems like this before? Yes No

If yes, when? _____

Are you presently seeing another therapist? Yes No

If yes, please provide the following information:

Therapist's name: _____ Date treatment began: _____

Therapist's address:_____

Therapist's phone number: _____

_____

_____

Date(s) of treatment : _____

Problem for which treatment was sought:_____

Treatment history

Have you previously been in psychotherapy or counseling, including individual, group, marital or family therapy?

Yes No

Name of therapist: _____ Dates: _____

Name of therapist: _____ Dates: _____

Name of therapist: _____ Dates: _____

If yes, in what way was it helpful? _____

If not, in what way was it unsatisfactory? _____

Has hospitalization or partial hospitalization for mental or emotional difficulties ever been recommended for you?

Yes No If yes, when and why? _____

Have you ever been hospitalized or participated in a partial hospitalization program for mental or emotional difficulties?

Yes No If yes, when and why? _____

Was the hospitalization voluntary? Yes No

Have you ever attempted suicide? Yes No If yes, when and how? _____

_____

Have you ever taken medications for mental or emotional difficulties prescribed by a physician/psychiatrist?

Yes No

If yes, what medications were prescribed, when and for what symptoms?

_____

Are you currently using any prescribed medications? Yes No

Please indicate what medications you are taking:

Medication Dosage When started Prescriber

_____

_____

_____

_____

General health

Do you currently have, or have you had in the past, any serious, chronic or recurrent health problems or disabilities?

Yes No

If yes, please describe: _____

List dates of any hospitalizations you have had for physical problems:

Date Problem

_____

_____

When was your last physical examination by a doctor? _____

What was the outcome? _____

Are there any other health care professionals (e.g. physicians, psychotherapists, etc.) whom you feel might have information that would help in your treatment?

Yes No

If yes, please give details: _____

_____

_____

_____

Do you currently smoke cigarettes? Yes No

If yes, approximate number of cigarettes per day? _____

Do you exercise regularly? Yes No

If yes, please list type of exercise and approximate frequency per week: _____

_____

_____

Substance use

Have you ever used any drugs or medications other than as prescribed? (This includes prescription medications, marijuana, PCP, LSD, amphetamines, barbiturates, cocaine, opiates, prescribed drugs (e.g. valium), Ecstasy and others): Yes No

Are you currently using? Yes No

If yes, list what and approximate frequency: _____

_____

Do you drink alcohol? Yes No

1. On average, how often did you have a drink containing alcohol in the past year?

☐ Never ☐ Monthly or less ☐ 2 to 4 times a month ☐ 2 to 3 times per week ☐ 4 or more times a week

2. How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

3. How often did you have six or more drinks on one occasion in the past year?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

4. In the past year, did you ever drink or use more drugs than you meant to? Yes No

5. Have you felt you wanted or needed to cut down on your drinking or drug use in the past year? Yes No

6. Has your drinking or drug use ever caused any problems in your work, school or relationships? Yes No

7. Has treatment for drug or alcohol abuse ever been recommended to you? Yes No

Abuse/trauma

Have you ever had a physical fight with anyone, including your spouse or partner (including throwing things, hitting, shoving, etc.)? Yes No

Did you ever have sexual contact with someone else that you did not want? Yes No

Have you experienced or witnessed any traumas (events that felt life-threatening)? Yes No

Have you experienced physical or sexual abuse or assaults? Yes No

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to? Yes No
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? Yes No
3. Were constantly on guard, watchful, or easily startled? Yes No
4. Felt numb or detached from others, activities, or your surroundings? Yes No

Miscellaneous

Have you ever been involved in a lawsuit?

Yes No

If yes, please describe the circumstances and give dates.

_____

_____

Have you ever been arrested for a crime?

Yes No

If yes, please describe the circumstances and give dates.

_____

_____

Have you experienced any particular sources of stress in the last year?

Yes No

If yes, please explain: _____

_____

Is there any other background information you think would be helpful for me to know?

Yes No

If yes, please explain: _____

_____

_____

_____

_____ _____

Signature Date