

# 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:

<u>Name</u>	<u>Age</u>	<u>Occupation</u>	<u>Where does s/he live?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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:

<u>Type of job held</u>	<u>How long?</u>
_____	_____
_____	_____
_____	_____

**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
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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, please list which ones and fill out the requested information:

Type	Frequency/amount	Duration	How taken
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If you have used any substances listed above, do you feel they have caused any problems in your work, school or relationships? Yes No

If yes, please explain: \_\_\_\_\_

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Do you drink alcohol? Yes No

If yes, please answer the following questions:

Have you ever felt you ought to cut down on your drinking? Yes No

Have people annoyed you by criticizing your drinking? Yes No

Have you ever felt bad or guilty about your drinking? Yes No

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

Yes No

How much alcohol do you drink? \_\_\_\_\_ drinks per \_\_\_\_\_

Do you feel your drinking has caused any problems in your work, school or relationships? Yes No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Has treatment for drug or alcohol abuse ever been recommended to you?

Yes No

If yes, please describe the circumstances and give dates.

\_\_\_\_\_

\_\_\_\_\_

Have you ever been treated for drug or alcohol abuse?

Yes No

If yes, please describe the provider and program, give dates and describe the outcome.

\_\_\_\_\_

\_\_\_\_\_

### 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

### 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.

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

Yes No

If yes, please explain: \_\_\_\_\_

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

Yes No

If yes, please explain: \_\_\_\_\_

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\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date