

# 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: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Sex (circle): Male or Female Gender: \_\_\_\_\_

Sexual orientation: \_\_\_\_\_

Ethnic background (circle)? Hispanic or Latino Non-Hispanic

Racial background (check)?

1. American Indian or Alaska Native

2. Asian

3. Native Hawaiian or Other Pacific Islander

4. Black or African American

5. White or European American

6. More than one race / other: \_\_\_\_\_

Religious background (circle): Protestant Catholic Jewish Muslim Buddhist No affiliation

Other: \_\_\_\_\_

Marital status (circle): Single, never married Married Cohabiting Separated Divorced Widowed

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:

<u>Name</u>	<u>Relationship</u>
_____	_____
_____	_____
_____	_____
_____	_____

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:

<u>Name</u>	<u>Age</u>	<u>Biological?</u>	<u>Name</u>	<u>Age</u>	<u>Biological?</u>
_____		<u>Y / N</u>	_____		<u>Y / N</u>
_____		<u>Y / N</u>	_____		<u>Y / N</u>

### 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:

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: \_\_\_\_\_ Therapist's phone number: \_\_\_\_\_

Date treatment began: \_\_\_\_\_ 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: \_\_\_\_\_  
\_\_\_\_\_

How much bodily pain have you had during the past 4 weeks (check)?

None     Very Mild     Mild     Moderate     Severe     Very Severe

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: \_\_\_\_\_  
\_\_\_\_\_

How would you describe the quality of your nightly sleep? \_\_\_\_\_

How many hours do you sleep on average per night? \_\_\_\_\_

### 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

### Mood and Anxiety

Over the last 4 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest of pleasure in doing things .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Trouble concentrating on things, such as reading the news or watching television .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Feeling nervous, anxious, on edge, or worrying a lot about different things.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. In the last 4 weeks, have you had an anxiety attack, where you suddenly felt fear or panic? 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

Do you feel safe in your home? 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.

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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