Manhattan Psychology Group, PC
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Testing Intake Questionnaire: Adult

Patient Information
Please fill out the following questions to the best of your ability

Name:

Date of birth:

Sex assigned at birth:

Address:

Telephone number:

Age:

Referred by:

Referral question or presenting problem:

Primary physician (please include telephone and address):

Other specialists (include name and specialty):

Medical History
Please fill out the following questions to the best of your ability

Previous hospitalizations, surgeries or accidents (describe when occurred, age, length of stay):

Serious illnesses:

Medical problems currently affecting you:

Family history of serious illnesses:

Previous loss of consciousness related to head injury or concussion. If yes, describe circumstances, when occurred, and medical treatment:

History of seizures? If yes, describe:

Other neurological disorders (stroke, hemorrhage, etc.)? If yes, describe:

Family history of neurological illness. If yes, describe:

Current medications (name and dosage):

Vision difficulties? If yes, describe:

Hearing difficulties? If yes, describe:

Psychiatric History
Please fill out the following questions to the best of your ability

History of emotional disorder/psychiatric treatment (diagnosis if known, age diagnosed, treating physician, medications prescribed):

When did you first seek psychiatric treatment?:

For what problems did you seek treatment?:

Was treatment helpful?:

Current psychiatrist (name, when treatment started, focus of treatment):

Current medications prescribed (name, dosage):

Medications taken in the past (name, dosage):

Current therapist (name, when treatment started, focus of treatment):

Inpatient hospitalizations (hospital, age, nature, and duration of treatment):

Previous suicide attempts (age, injuries):

Family history of psychiatric treatment or illness:

Previous/current use of (age began using, how long using, current usage): Nicotine:

Previous/current use of (age began using, how long using, current usage): Alcohol:

Have you ever experienced blackouts or withdrawal symptoms?:

Recreational drug use (specify drug, age began using, how long using, current usage):

Drug of choice (if any):

Formal treatment for drug or alcohol abuse (detoxification, rehabilitation, AA, or NA)? If yes, describe:

Personal History
Please fill out the following questions to the best of your ability

Place of birth:

Where raised:

Native Language:

Right handed, left handed, or ambidextrous:

Developmental milestone (e.g. walking, talking) attained early/late/within normal limits:

Education including high school (name of institution, degree obtained, year of graduation):

School problems (repeated grades, failed classes, special education, tutoring). If any, please describe:

Have you ever been diagnosed with a learning disability or Attention Deficit/Hyperactivity Disorder? If yes, when and by whom?:

Behavioral problems as a child? If yes, describe:

Current occupation (job title, company name):

How long have you worked at your current job?:

What was your last job?:

Previous work history:

Current marital status:

If married, separated, divorced, or widowed, please note when:

Please list those individuals who are living with you currently (Name, sex, age, relationship, education, occupation, health):

Please list family members who are NOT living with you currently (Name, sex, age, relationship, education, occupation, health):

Current Complaints
Please fill out the following questions to the best of your ability

Physical symptoms and changes

- [ ] Weakness
- [ ] Numbness
- [ ] Muscle tics/twitches
- [ ] Clumsiness
- [ ] Headache
- [ ] Pain
- [ ] Dizziness
- [ ] Nausea
- [ ] Visual defects
- [ ] Hearing defects
- [ ] Problem with taste
- [ ] Problem with smell
- [ ] Bladder/bowel control
- [ ] Change in appetite/weight
- [ ] Change in sleep pattern
- [ ] Seizures
- [ ] Fainting spells
- [ ] Other

Describe other:

Any recent changes in

- [ ] Appetite/Weight
- [ ] Sleep
- [ ] Energy levels
- [ ] Sexual interest/libido
- [ ] Other

Describe other:

Behavioral concerns

- [ ] Unusual fears
- [ ] Slowed response
- [ ] Destructiveness
- [ ] Irritability
- [ ] Excessive sadness
- [ ] Self-destruction
- [ ] Stubbornness
- [ ] Sleep problems
- [ ] High activity level
- [ ] Sexual difficulties
- [ ] Aggressiveness
- [ ] Restlessness
- [ ] Nightmares
- [ ] Easily frustrated
- [ ] Eating problems
- [ ] Mood swings
- [ ] Suicidal thoughts
- [ ] Isolated
- [ ] Withdrawn
- [ ] Problems with driving
- [ ] Other

Describe other:

Intellectual concerns

- [ ] Difficulty planning or organizing
- [ ] Difficulty in completing activities
- [ ] Difficulty adapting to change (rigid)
- [ ] Inability to concentrate
- [ ] Easily distracted
- [ ] Impulsive
- [ ] Difficulty learning or remembering
- [ ] Difficulty with comprehension
- [ ] Difficulty with expression
- [ ] Gets lost easily
- [ ] Difficulty with reading
- [ ] Difficulty with math
- [ ] Periods of confusion or disorientation
- [ ] Slowed thought processes
- [ ] Changes in mood or personality
- [ ] Changes in the way you get along with others
- [ ] Changes in social activities
- [ ] Other

Describe other:

Are symptoms staying the same or getting worse?:

What is your best guess as to why the symptoms are happening?:

Has daily living at home, work, or in social situations been affected by your symptoms? If yes, describe:

What, if anything, has helped your symptoms?:

Wrap up

Please use section below to include additional relevant information: