
Intake Questionnaire

Patient Name: _____

Date of Birth: _____

Reason(s) for Referral

Primary Concern:

Has the patient received treatment for this concern in the past year?

☐ Yes ☐ No

If yes, please check any providers seen in the past year:

- ☐ Inpatient Treatment
- ☐ Outpatient Therapist
- ☐ Psychiatrist
- ☐ Developmental Pediatrician
- ☐ Neurologist
- ☐ School Counselor
- ☐ Other (please specify): _____

Please describe the primary concern in more detail:

Current Symptoms (check all that apply):

- ☐ Sadness, guilt, or crying spells
- ☐ Difficulty concentrating or initiating tasks
- ☐ Hyperactivity, impulsivity, or racing thoughts
- ☐ Anxiety, excessive worry, or panic attacks
- ☐ Mood swings or irritability
- ☐ Loss of interest or social withdrawal
- ☐ Fatigue or sleep difficulties
- ☐ Paranoia, detachment from reality, or hallucinations
- ☐ Difficulty managing daily stress
- ☐ Challenges relating to others
- ☐ Risky behaviors or substance use
- ☐ Appetite or eating habit changes
- ☐ Anger, aggression, or hostility
- ☐ Suicidal thoughts, self-harm, or intrusive thoughts of death
- ☐ Changes in sex drive (if applicable)
- ☐ Other (please specify): _____

Developmental and Medical History

Developmental Milestones- Were early developmental milestones (e.g., walking, talking, toileting) met on time?

[Yes / No – please explain if no]

Significant Medical Conditions- *Include any congenital injuries, serious illnesses, impairments, or broken bones. Please include the date of incident or diagnosis and whether the condition is ongoing or resolved.*

- Condition:
- Date of Diagnosis/Incident:
- Current Status: [Ongoing / Resolved]
- Notes:
- (Repeat fields as needed)

Moderate Medical Conditions- *Include allergies, sensory sensitivities, and chronic but manageable health issues. Please include the date of onset and current status.*

- Condition:
- Date of Identified:
- Current Status: [Ongoing / Resolved]
- Notes:
(Repeat fields as needed)

Major Surgeries- *List any major surgeries, past or planned. Include dates and relevant details.*

- Surgery:
- Date:
- Notes:
(Repeat fields as needed)

Other Relevant Medical History- *Please include any additional medical information that may be relevant to the evaluation or care.*

- Description:

Family and Social History

Who lives in the home? (Names, ages, and relationship to patient):

Where was the patient born? (City, state)

Where has the patient lived? (City, state, and duration):

Languages spoken at home:

How does patient get along with others (ability to make friends, maintain social relationships, get along with family):

Activities and interests the patient enjoys:

Please complete the following family and social history questions if applicable, based on the patient's age and life circumstances.:

Primary caregiver(s):

Participation in childcare or afterschool programs:

Are the patient's parents currently married?

☐ Yes ☐ No

If no:

- Age at separation:
- Custody or visitation schedule (if applicable):
- Did either parent remarry?
☐ Yes ☐ No
- If yes, which parent(s) and at what age?:

Marital Status (for adults):

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other: _____

If applicable:

Date of Marriage:

Date of Divorce:

Number of Prior Marriages:

Does the patient have children?:

If yes, please describe the relationship and list children's ages:

Does the patient participate in a religion or spiritual group?:

Has the patient ever had legal involvement/arrests?

☐ Yes ☐ No

If yes, when and why?:

Mental Health and Psychiatric History

Previous psychiatric evaluations?

☐ Yes ☐ No

If yes, please include type, provider/agency, and date:

Previous diagnoses?

☐ Yes ☐ No

If yes, please include diagnosis, provider, and date:

Prior psychological/psychiatric treatment?

☐ Yes ☐ No

If yes, please provide provider/agency, dates, and type of treatment:

Traumatic experiences?

☐ Yes ☐ No

If yes, please include date(s) and provide additional information about those experiences:

Family history of psychiatric conditions:

Include relationship and diagnosis (e.g., "sister – depression")

Current Medications

List all medications currently being taken, including dosage, prescriber, start date, and reason for use.

- Name:

- Dosage:

- Prescriber:

- Start Date:

- Reason:

(Repeat fields as needed)

Medications Taken in the Past Year (No Longer Prescribed)

Include name, dosage, prescriber, dates of use, and reason for discontinuation.

- Name:

- Dosage:

- Prescriber:

- Dates Taken:

- Reason Discontinued:
(Repeat fields as needed)

Substance Use and Sexual History (complete) as applicable to the patient)

Has the patient ever used any of the following substances? (Check all that apply)

- ☐ Alcohol
- ☐ Tobacco (cigarettes, cigars)
- ☐ Vapes/e-cigarettes (nicotine or THC)
- ☐ Marijuana (including edibles or vapes)
- ☐ Prescription medications not prescribed to them (e.g., Xanax, Adderall)
- ☐ Over-the-counter medications to get high (e.g., cough syrup, Benadryl)
- ☐ Edibles or gummies with THC or CBD
- ☐ Illegal or high-risk drugs (e.g., cocaine, fentanyl, heroin, methamphetamines)
- ☐ Other substances (please specify): _____

If yes to any, provide details (dates, frequency, context):

Has the patient ever received treatment for substance use? ☐ Yes ☐ No

If yes, provide dates and details:

Has the patient misused prescription medications? ☐ Yes ☐ No

If yes, which ones?:

Does the patient currently:

Smoke cigarettes/vape? ☐ Yes ☐ No

If yes, how many per day: _____

Drink caffeinated beverages? ☐ Yes ☐ No

If yes, how many per day: _____

Engage in sexual activity (not including intercourse) ☐ Yes ☐ No

Engage in sexual intercourse ☐ Yes ☐ No

Educational and Vocational History

Current School/Employer:

Current/Highest Grade Level:

Type of School (if applicable):

☐ Public ☐ Private ☐ Charter ☐ Specialized ☐ Other: _____

Has the patient ever repeated or skipped a grade?

☐ Yes ☐ No If yes, please explain: _____

Does the patient currently receive special education services (or received in the past)?

☐ Yes ☐ No

If yes, please specify the services received (e.g., ICT, SETSS, OT, PT, Speech):

If yes, Does the patient have/had an Individualized Education Program (IEP) or a 504 Plan?

☐ IEP ☐ 504 Plan ☐ Other

Date of most recent IEP/504 Plan: _____

Has the patient ever undergone educational or neuropsychological testing?

☐ Yes ☐ No

If yes, please provide the date, provider, and type of evaluation:

Have any learning difficulties or disabilities been identified?

☐ Yes ☐ No

If yes, please explain: _____

Does the patient receive academic or tutoring support outside of school (if applicable)?

☐ Yes ☐ No If yes, please describe: _____

How does/did the patient typically perform in school (academically and socially)?

Has the patient experienced any school-related concerns (e.g., school refusal, suspensions, bullying, attendance issues)?

☐ Yes ☐ No If yes, please explain: _____

Is the patient employed? (for older teens/adults)

Employer & Occupation (if applicable):

Thank you for completing this form. Is there anything else you would like to share that might help us better understand the patient's needs?