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 Incident:

- Current Status: [Ongoing / Resolved]

- Notes: (Repeat fields as needed)

Impairments – *Please note any auditory or vision impairments we should be aware of.*
This information is important across all of our services and is particularly relevant for testing, as some evaluations involve visual or auditory components (for example, colors, sounds, or depth perception).

- Condition:

- Date of Incident:

- 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 patient's age and life applicable, based on the 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?