

## Psychiatry Clinic Intake Questionnaire

Patient Name \_\_\_\_\_ TX State ID# \_\_\_\_\_ Date \_\_\_\_\_

**Marital Status**   Married          Single          Divorced

**Children**          Y          N

**Do you have private health insurance?**   Y          N

**Are you a client of DARS (Department of Assistive and Rehabilitative Services)?**   Y          N

**Who referred you to the Psychiatrist?** SHC PHYSICIAN \_\_\_\_\_

COUNSELING CENTER \_\_\_\_\_

**Briefly describe the problems/concerns you have:** \_\_\_\_\_

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**What led you to seek help now?** \_\_\_\_\_

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**What makes the problem worse?** \_\_\_\_\_

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**What makes the problem better?** \_\_\_\_\_

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**What has changed in your life because of your primary concern?** \_\_\_\_\_

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TX State ID# \_\_\_\_\_ Date \_\_\_\_\_

**Mark an X in the box that best describes:**

<b>Sleep</b>	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Extreme</b>
sleeping too much				
difficulty falling asleep				
difficulty staying asleep				
waking earlier than desired				
<b>Interests</b>	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Extreme</b>
loss of interest in pleasurable activities				
changes in sexual interest				
<b>Self-esteem/Guilt</b>	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Extreme</b>
excessive guilt				
feeling worthless				
regretting some behaviors				
<b>Energy</b>	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Extreme</b>
decreased energy				
increased energy				
unable to sit still				
moving so slowly that others have noticed				
<b>Memory, Concentration, Perceptions</b>	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Extreme</b>
difficulties with concentration				
worry about social or performance situations				
seeing things that others may not see				
hearing things that others may not hear				
<b>Appetite</b>	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Extreme</b>
increased appetite				
decreased appetite				
restricting what you eat to lose more weight				
overeating/making yourself vomit				
<b>Mood</b>	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Extreme</b>
mood swings				
feeling sad or depressed				
feeling nothing or feeling numb				
anger				
temper outbursts				
irritability				
inability to stop worrying				
anxiety or fear				
<b>Other</b>	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Extreme</b>
avoiding places, people, or situations				

TX State ID# \_\_\_\_\_ Date \_\_\_\_\_

**Mark an X in the box that best describes:**

Risk Assessment	Currently	In last 6 mos	More than 6 months ago	Never
Recurrent thoughts about death				
Believing that others would be "better off" if you were dead				
Feeling hopeless about your life and future				
A family member or close friend completing suicide				
Self-harming behaviors without intent to die				
Recurrent thoughts about killing yourself				
Thinking out a plan to kill yourself				
Active preparation to kill yourself				
Attempting to kill yourself				
Recurrent thoughts about killing others				
Thinking out a plan to kill someone else				
Active preparation to kill someone else				
Attempting to kill someone else				
Voices telling you to hurt or kill yourself or others				
Being more physically or verbally aggressive than you intended to be (with spouse/partner/child)				
A physical altercation in which you caused injury				
Throwing or breaking things when angry				
Arrest for physical violence				

TX State ID# \_\_\_\_\_ Date \_\_\_\_\_

**Mark an X in the box that best describes any current symptoms:**

<b>Review of symptoms</b>			
Dry mouth		Tics/Twitches	
Constipation		Trembling/shaking	
Sweating		Excessive snoring	
Fatigue		Taking medication to sleep	
Nightmares		Fainting or dizzy spells	
Constant pain		Unexplained weight loss	
Nausea		Unexplained weight gain	
Diarrhea		Changes in hearing or vision	
Blackouts		Numbness in extremities	
Headaches		Sexual concerns	
Other			

**Mark an X in the box of the family member who has had the following:**

<b>Family History</b>	<b>Mother</b>	<b>Father</b>	<b>Sibling</b>	<b>Grandparent</b>	<b>Aunt/Uncle</b>
Attention deficit disorder (ADD/ADHD)					
Bipolar or Manic/Depressive illness					
Alcohol or Drug Abuse					
Mental retardation					
Depression					
Anxiety (panic disorder, excessive worry)					
Learning disability					
Schizophrenia or psychosis					
Other					

**Mark an X by all that apply:**

<b>Life Experiences</b>					
Abusive relationship		Miscarriage		Unhappy childhood	
Experienced physical abuse		Abortion		Poor academic progress	
Experienced emotional abuse		Crime Victim		Few Friends	
Experienced sexual abuse		War		Family Problems	
Witnessed physical abuse		Poverty			
Witnessed emotional abuse		Natural Disaster			
Witnessed sexual abuse		Death of a parent			
Rape		Death of someone close			

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**Mark an X by all that apply:**

<b>Psychological Health History</b>	
saw a physician for a mental health concern	
was prescribed medication for a mental health condition	
saw a therapist or counselor	
received substance abuse counseling or treatment	
saw a psychiatrist for a mental health condition	
ever hospitalized for a mental health condition	
ever diagnosed with an eating disorder	
<b>Occupational History</b>	
frequently quit jobs/don't stay at a job long	
usually get fired from a job	
financial difficulties	
unemployed	
<b>Academic History</b>	
attended more than one college	
on academic probation or suspension	
suspended or expelled from school	
needed to take classes over (or repeat a grade)	
skipped a grade	
learning disability/ADHD (previously diagnosed)	

**Current GPA:** \_\_\_\_\_

**Major/minor:** \_\_\_\_\_

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**Mark an X by all that apply:**

Substance Use	Currently	In last 6 mos	More than 6 mos ago	Never
tobacco				
marijuana				
IV drugs				
cocaine				
heroin				
ecstasy				
selling or trading prescription medicine given to you				
prescription medication for recreational use				
overuse of a prescription medication				
taking prescription medication for reasons other than it was prescribed				

**Do you drink alcohol?**    Y    N

- how many days of the month do you drink? \_\_\_\_\_
- how many drinks do you drink on one day/night? \_\_\_\_\_
- do you drink to get drunk or to get away from stressors? \_\_\_\_\_
- has your alcohol use increased in the past month? \_\_\_\_\_
- have you had problems in your relationships due to alcohol use? \_\_\_\_\_
- have you had problems at work or at home due to alcohol use? \_\_\_\_\_
- have you blacked out in the past from drinking alcohol? \_\_\_\_\_
- have you received treatment for use of alcohol (including Alcoholics Anonymous)? \_\_\_\_\_
- do you drive after drinking alcohol? \_\_\_\_\_
- have you had trouble with the law due to alcohol use (i.e. DUI, public intoxication)? \_\_\_\_\_

**Do you drink caffeinated beverages?**    Y    N

how many drinks in an average day? \_\_\_\_\_

I understand the questionnaire information I have provided is important in assessing the health care I may need. I certify that the information on this form is true and accurate to the best of my knowledge.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Psychiatrist Signature \_\_\_\_\_ Date \_\_\_\_\_