alo·ha psych ASSOCIATES, INC.

INTAKE QUESTIONNAIRE

All information is considered confidential and will not be released without your written consent or as required by law

Name	Date of Birth	Age
Address:		
City	State	Zip
Home Phone Number	Work Number	Other Number (i.e. cell phone)
Can we leave confidential messages at: **Home** ☐ Yes ☐ No	**Work** ☐ Yes ☐ No	**Other** ☐ Yes ☐ No
Ethnicity/Race	Primary Language	How were you referred to our office?

What brings you to our office? Briefly describe your current difficulties.

Who lives in your home with you?

Marital/Relationship Status: Spouse/Partner/Significant other's first name:

Please list the number of times you have been: Divorced _____ Widowed _____

Please list all children (including step-children and children who do not live with you):

Name of Child	Age	Sex	Do they live with you?	Quality of your Relationship

All information is considered confidential

Please indicate if the following have caused distress:

Ever	Now		Ever	Now	
		School problems			Legal problems
		Financial problems			Relationship problems
		Childhood issues			Memory problems
		Career problems			Sexual concerns
		Sadness			Don't need as much sleep
		Lack of enjoyment in activities			Racing thoughts
		Difficulty starting anything			Short attention span
		Change in appetite			Talking a lot (more than normal)
		Weight loss or gain			Feeling on top of the world
		Sleep problems (too much / not enough)			Irritability
		Fatigue / feeling tired			Worried
		Feelings of worthlessness			Jittery / jumpy / restless
		Guilt			Increased muscle tension
		Difficulty focusing / Easily distracted			Heart racing / chest pain
		Loss of interest in others			Trembling / shaking
		Difficulties making decisions			Smothering / shortness of breath
		Thoughts of hurting self			Choking sensation
		Suicidal thoughts			Nausea
		Urge to hurt someone else			Dizzy / faint / lightheaded
		Hopelessness			Feeling detached from self / feelings of unreality
		Eating out of control			Fear of losing control or going crazy
		Recurring thoughts that can't be controlled			Fear of dying
		Flashbacks (re-experiencing a past event)			Numbness or tingling
		Traumatic event			Chills or hot flushes
		Recent loss			Avoiding public places
		Concern about weight			Concern others are judging / watching you
		See or hear things others don't			Unusual thoughts or ideas
		Intentionally skipping meals			Urges to repeat behaviors

All information is considered confidential

Family Information

Who were you raised by? _____

Family Psychological History

	Psychological/Emotional/Substance Use Issue (depression, anxiety, ADHD, alcoholism)	Any Treatment	Ever Hospitalized for Psychological/Emotional/ Substance Use Issues
Mother			
Father			
Siblings			
Other Relatives			

Parent's current marital status: Married Separated Divorcing Divorced Remarried Widowed Both deceased

If your parent's are divorced/widowed:
How old were you when your parents divorced or when your parent died?

If your parent's are divorced/widowed/remarried:
How old were you when your parents remarried?

As a child, were you closer to your mother or father?

In a word or phrase, how would you describe your childhood environment?

Did you meet developmental milestones (walking, talking, etc.) at appropriate times? ☐ Yes ☐ No

Have you ever lost a member of your family or someone close to you through death? ☐ Yes ☐ No
If so, whom did you lose, what was the cause of death, how old were you at the time, and how did you react?

Please describe any fearful/distressing/traumatic childhood experiences:

Please list any siblings (living and deceased):

Name	Age	Sex	What city do they live in	Quality of your Relationship

All information is considered confidential

Medical History:

Have you or a family member ever been diagnosed with the following?

Diagnosis	Self	Relative	Diagnosis	Self	Relative
Speech problems			Premature birth		
Vision problems			Lung / respiratory problems		
Hearing problems			Frequent ear infections		
Learning disability			Headaches		
Developmental delay			Chronic Pain		
Mental Retardation			Fibromyalgia		
Autism			Allergies		
Attention problem			Diabetes		
Hyperactivity			High blood pressure		
Substance abuse			High cholesterol		
Alcoholism			Heart disease		
Legal problems			Cancer		
Victim of domestic violence			AIDS or HIV+		
Sexual abuse or Rape victim			Stroke or TIA		
Physical abuse victim			Seizures / Epilepsy		
Depression			Perpetrator of abuse toward another person		
Bipolar disorder (manic-depression)			Memory problems		
Anxiety			Dementia / senility / Alzheimer's		
Eating disorder			Hazardous substance exposure		
Personality Disorder			Excessive exposure to lead		
Schizophrenia			Injury requiring hospitalization		
Suicide attempt			Head injury		
Other psychiatric illness:			Other:		

Current health care provider: _____ Phone Number: _____

Date of last visit: _____ Reason for last visit: _____

Please list all current medications (both prescription and over-the counter):

Medication	Prescribed by	For	Dosage	Side-Effects

Allergies:

All information is considered confidential

Substance Use: Please indicate your usage of the following substances:

Substance	Currently use	Used in the past	Average Usage
Caffeine (coffee/tea/soda pop)			
Tobacco			
Alcohol			
Marijuana			
Prescription Drugs (misuse)			
Inhalants			
Hallucinogens (LSD/Ecstasy/PCP/mushrooms)			
Opiates (Heroin/Morphine)			
Steroids (misuse)			
Stimulants (Meth/Crack/Cocaine/Crank)			

In the past 12 months, has your substance use **repeatedly** caused or contributed to:

- Interference with home, work, or school obligations ☐ Yes ☐ No
- Risk of bodily harm (drinking and driving, operating machinery, swimming) ☐ Yes ☐ No
- Run-ins with the law (arrests or other legal problems) ☐ Yes ☐ No
- Relationship trouble (family or friends) ☐ Yes ☐ No

In the past 12 months, have you:

- Needed to use substances a lot more to get the same effect ☐ Yes ☐ No
- Shown signs of withdrawal such as tremors, sweating, nausea, or insomnia when trying to quit or cut down ☐ Yes ☐ No
- Not been able to stick to limits you set for yourself ☐ Yes ☐ No
- Not been able to cut down or stop ☐ Yes ☐ No
- Spent a lot of time using, anticipating using, or recovering from using ☐ Yes ☐ No
- Spent less time on other activities that had been important or pleasurable in the past ☐ Yes ☐ No
- Kept using substances despite problems ☐ Yes ☐ No

Have you ever been treated for substance usage problems? ☐ Yes ☐ No

Dates	Provider	Focus of Treatment (Substance)

Psychological Treatment History:

Please list all previous psychotherapy, counseling, or other treatment for personal and/or marital problems:

Dates	Provider	Focus of Treatment

Have you ever thought of taking your own life? ☐ Yes ☐ No

Have you ever attempted to hurt yourself? ☐ Yes ☐ No

Have you ever attempted to end your own life? ☐ Yes ☐ No

If yes: How many times: _____ How:

When:

All information is considered confidential

Educational History:

Are you currently in school? ☐ Yes ☐ No If so, where? _____

What is your highest level of education (last grade or degree completed): _____

When did you graduate? Or if you are still in school, when will you graduate? _____

What type of student were/are you? What type of grades did you get? _____

Did any of the following occur during childhood?

✓		✓	
	Difficulty making friends		Participated in extracurricular activities (i.e sports/clubs)
	Teased / Bullied by others		Difficulty concentrating in class
	Suspended or Expelled		Tutoring
	Getting into physical fights		Attended special program
	Repeated a grade / Held back		Failed a class
	Truancy / Skipped class frequently		Changed schools due to a move
	Refused to go to school		Removed from home due to abuse/neglect
	Skipped a grade		Attended pre-school (i.e. Headstart)

Employment History:

Please list your work history, beginning with your **current** job and working backward:

Employer	Position Held	Dates	Reason Left

Military History **If no military history please check here: ☐**

Branch: _____ Dates enlisted: _____

Discharge Rank: _____ Type of discharge: _____

Did you sustain any physical injuries in the military? ☐ Yes ☐ No

Please list injuries:

All information is considered confidential

Legal History

If no legal history please check here: ☐

Please list any legal charges you have received even if you were not prosecuted for the crime: (not including minor traffic violations).

Date	Charges (MPI / DUII / Assault / Domestic Violence)	Outcome/Convictions

Do you currently have any legal involvements, including civil actions (being sued)? ☐ Yes ☐ No Please list:_____

_____

Daily Living:

What is your religious affiliation? _____

Do you currently practice? ☐ Yes ☐ No

Please rate the importance of your spiritual beliefs:

Not important at all	Somewhat Important	Very important
1	5	10

What are your current hobbies, interests, or ways you use your free time? _____

_____

Have you changed your level of involvement in any of these activities recently? ☐ Yes ☐ No

Do you exercise on a regular basis? ☐ Yes ☐ No If so what do you do: _____

How do you cope with stressful situations? _____

What is your greatest strength? (What do you do the best/ What are you most proud of) _____

_____

Other:

Is there anything else that is important for me to know that is not listed on this form? If so please write about it here: