

**INTAKE INFORMATION FORM**

**Part I: To Be Completed By All Patients**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |       | Date of Birth: |       | Age: |       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Gender: |       | Ethnicity: |       | Education Attained: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Marital/Partner Status: |       | Sexual Orientation: |       |

|  |  |
| --- | --- |
| Full Address: |       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Cell Phone: |       | Home Phone: |  | Work Phone: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Leave voicemail? | [ ]  No [ ]  Yes | Leave message if someone else answers phone? | [ ]  No [ ]  Yes |

|  |  |  |  |
| --- | --- | --- | --- |
| Email: |       | Email Appointment Reminder: | [ ]  No [ ]  Yes |

You will automatically be subscribed to our monthly newsletter. This is a means of communicating important and useful information about the clinic and related topics. You can unsubscribe at any time at the bottom of the email.

|  |  |
| --- | --- |
| Preferred Contact? | [ ] Cell [ ]  Home [ ]  Work [ ]  Email  |

|  |  |  |  |
| --- | --- | --- | --- |
| Occupation: |       | Household Income: |       |

|  |  |
| --- | --- |
| Work/School (Please circle) Name & Address: |       |

|  |
| --- |
|       |

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| --- | --- |
| ***Referred By:*** | [ ]  Google->Clinic Website [ ]  Facebook [ ]  Twitter [ ]  LinkedIn [ ]  Yelp |

|  |
| --- |
| [ ]  International OCD Foundation (IOCDF) Directory [ ]  The TLC Foundation for BFRB Directory [ ]  Healthgrades |

|  |
| --- |
| [ ]  Anxiety & Depression Association of America (ADAA) Directory [ ]  PsychologyToday |

|  |  |
| --- | --- |
| [ ]  Medical/Mental Health Professional (Specify): |       |

|  |  |
| --- | --- |
| [ ]  Other (Specify): |       |

|  |  |  |
| --- | --- | --- |
| ***Current Psychiatrist*** | Name: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Full Address: |       | Phone: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Fax Number: |       | Email: |       |

|  |  |  |
| --- | --- | --- |
| ***Current Primary Care Physician/Pediatrician*** | Name: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Full Address: |       | Phone: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Fax Number: |       | Email: |       |



**Part II: History**

**Presenting Problem(s): Duration:**

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| --- | --- | --- |
|  |  |       |

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**Current Medications:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name:** |  | **Dose(mg)/day:** |  | **Prescribed for:** |  | **Prescribed by:** |
|       |  |       |  |       |  |       |
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|       |  |       |  |       |  |       |

**Help Seeking History:**

List in chronological order any outpatient help and/or hospitalization for behavioral/psychological problems.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Dates (from…to…)** |  | **Clinic / Institution** |  | **Name & Profession (e.g., psychologist, psychiatrist, social worker, counselor, nurse)** |  | **Reason for Therapy** |  | **Treatment Type (e.g., talk therapy, CBT, medication)** |  | **Frequency of visit (e.g., 1x/week, inpatient)** |
|       |  |       |  |       |  |       |  |       |  |       |
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**Typical Response to Stress:**

|  |  |
| --- | --- |
| [ ]  Talking things out / think things through | [ ]  Avoidance / withdrawal |
| [ ]  Take direct action / seek guidance / problem solve | [ ]  Alcohol/drug use |
| [ ]  Exercise / sports | [ ]  Anger  |
| [ ]  Passive activities (reading, journaling, TV, Internet) | [ ]  Do something impulsive |
| [ ]  Relaxation techniques | [ ]  Cry |
| [ ]  Social support | [ ]  Use humor |
| [ ]  Hobbies | [ ]  Other:       |
| [ ]  Religion  |  |



**Family History:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Anxiety / Depression / Bipolar** | **Alcohol / Drug Abuse** | **Psychosis /****Schizophrenia** | **Attention /****Behavior / Conduct Problem** | **Learning Disabilities** | **Health Problems** |
| **M****other’s Side** |  |
| Grandmother |       |       |       |       |       |       |
| Grandfather |       |       |       |       |       |       |
| Mother |       |       |       |       |       |       |
| Aunt |       |       |       |       |       |       |
| Uncle |       |       |       |       |       |       |
| **Father’s Side** |  |
| Grandmother |       |       |       |       |       |       |
| Grandfather |       |       |       |       |       |       |
| Father |       |       |       |       |       |       |
| Aunt |       |       |       |       |       |       |
| Uncle |       |       |       |       |       |       |
| **Siblings** |  |
| Brother |       |       |       |       |       |       |
| Sister |       |       |       |       |       |       |

**Children:**

Do you have any children? If so, please complete this section. Otherwise, skip to the General Social History section.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name:** |  | **Lives at Home?** |  | **Age:** |  | **School / Grade / Work** |
|       |  |       |  |       |  |       |
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|       |  |       |  |       |  |       |
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|       |  |       |  |       |  |       |

**General Social History:**

Which best describes your social history?

[ ]  Supportive social network [ ]  Distant from family of origin [ ]  No friends [ ]  Family conflict

[ ]  Substance-use based friends [ ]  Few Friends



**Health History:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Current physical health: | [ ]  Good | [ ]  Fair | [ ]  Poor | Date of last physical exam: |     |

|  |  |
| --- | --- |
| Date of first menstruation (if applicable): |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Asthma | [ ]  Past | [ ]  Present | Surgery | [ ]  Past | [ ]  Present |
| Adrenal (cortisol) problems | [ ]  Past | [ ]  Present | Lengthy hospitalization | [ ]  Past | [ ]  Present |
| Allergies | [ ]  Past | [ ]  Present | Speech/language problem | [ ]  Past | [ ]  Present |
| Arthritis | [ ]  Past | [ ]  Present | Chronic ear infections | [ ]  Past | [ ]  Present |
| Birth defects | [ ]  Past | [ ]  Present | Hearing difficulties | [ ]  Past | [ ]  Present |
| Diabetes/Hypoglycemia | [ ]  Past | [ ]  Present | Eye/vision problems | [ ]  Past | [ ]  Present |
| Hyperhidrosis (sweating problems) | [ ]  Past | [ ]  Present | Fine motor/handwriting problems | [ ]  Past | [ ]  Present |
| Pregnancy | [ ]  Past | [ ]  Present | Gross motor difficulties | [ ]  Past | [ ]  Present |
| Chicken pox / shingles | [ ]  Past | [ ]  Present | Stroke | [ ]  Past | [ ]  Present |
| Heart disease | [ ]  Past | [ ]  Present | Soiling problems | [ ]  Past | [ ]  Present |
| High blood pressure | [ ]  Past | [ ]  Present | Wetting problems | [ ]  Past | [ ]  Present |
| High fevers (over 103**°**) | [ ]  Past | [ ]  Present | Epilepsy/seizures | [ ]  Past | [ ]  Present |
| Broken bones | [ ]  Past | [ ]  Present | Cancer | [ ]  Past | [ ]  Present |
| Severe cuts needing stitches | [ ]  Past | [ ]  Present | Tuberculosis | [ ]  Past | [ ]  Present |
| Head injury / loss consciousness | [ ]  Past | [ ]  Present | Alzheimer's disease/dementia | [ ]  Past | [ ]  Present |
| Lead poisoning | [ ]  Past | [ ]  Present | Thyroid problems | [ ]  Past | [ ]  Present |
| Other chronic illnesses:      | [ ]  Past | [ ]  Present | Other childhood illnesses:      | [ ]  Past | [ ]  Present |

**History of Alcohol/Nicotine/Substance Use:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Substance(s) Used:** | **Age of First Use** | **Age of Last Use** | **How was it taken?** | **Amount per day** | **Days per month** |
| Alcohol (e.g., beer, cocktails, shots, hard liquor) |       |       | [ ]  Oral [ ]  Nasal [ ]  Inhaled [ ]  Injected |       |       |
| Nicotine (e.g., cigarettes, chewing tobacco) |       |       | [ ]  Oral [ ]  Nasal [ ]  Inhaled [ ]  Injected |       |       |
| Amphetamines (e.g., Speed, Methamphetamine, Phenmetraline, Khat, Betel nut, Ritalin, Methylphenidate) |       |       | [ ]  Oral [ ]  Nasal [ ]  Inhaled [ ]  Injected |       |       |
| Opiates (e.g., smoked heroin, Heroin, Opium) |       |       | [ ]  Oral [ ]  Nasal [ ]  Inhaled [ ]  Injected |       |       |
| Cocaine (e.g., Crack, Freebase, Coca leaves) |       |       | [ ]  Oral [ ]  Nasal [ ]  Inhaled [ ]  Injected |       |       |
| Hallucinogens (Ecstasy, LSD, Mescaline, Peyote, PCP, angel dust (Phencyclidine), Psilocybin, DMT (Dimethyltryptamine), bath salts |  |  |  |  |  |
| Solvents/Inhalants (e.g., glue, aerosols, thinner, trichloroethylene, gasoline/petrol, gas) |       |       | [ ]  Oral [ ]  Nasal [ ]  Inhaled [ ]  Injected |       |       |
| Cannabis (e.g., Marijuana, Hash, Hash oil) |       |       | [ ]  Oral [ ]  Nasal [ ]  Inhaled [ ]  Injected |       |       |
| Sleeping pills/Benzodiazepines (e.g., Valium, Klonopin, Ativan, Xanax)/pain killers |       |       | [ ]  Oral [ ]  Nasal [ ]  Inhaled [ ]  Injected |       |       |
| Other:       |       |       | [ ]  Oral [ ]  Nasal [ ]  Inhaled [ ]  Injected |       |       |



**Symptom Screener**

Office Use

1. I have frequent thoughts, urges, or images that I don't want to have

**Yes No** (for example, thoughts about being contaminated even though I may not be, or that I may hurt someone else even though I don’t want to).

7

2. I do repetitive behaviors (for example, hand washing or cleaning, ordering or arranging, checking things, or repeating behaviors over

**Yes No** and over), or I repeatedly do things in my mind (for example, counting, saying certain words or phrases) in order to feel better or to prevent something bad from happening.

7

**Yes No** 3. I spend a lot of time worrying about my physical appearance.

11

**Yes No** 4. My house is excessively cluttered.

14

**Yes No** 5. I frequently pull out hair from my scalp or my body.

18

**Yes No** 6. I frequently pick at my skin.

18

**Yes No** 7. I get very anxious or fearful in social situations or when I am being observed.

22

**Yes No** 8. I have had a panic attack, where I experienced a lot of fear and physical sensations that came out of the blue.

26

9. I feel very fearful or anxious in situations where it's difficult to escape

**Yes No** quickly or get help (for example, using public transportation, being in open or enclosed spaces, standing in line or being in a crowded place

or being alone away from home).

30

10. I feel excessively anxious or worried about many things, a lot of the

**Yes No** time (for example, worry about finances, responsibilities at work/school, my health or the health of others).

34

11. There are certain objects, situations, or activities that I am very afraid

**Yes No** of (for example, like animals, insects, blood, needles, heights, storms, flying, choking, vomiting, or enclosed spaces).

38

**Yes No** 12. I feel very afraid to be away from a certain person or people.

42

S

Please read the following statements and circle YES or NO to indicate whether each statement applies to

you. If you are not sure whether a statement applies to you, circle YES and ask your interviewer about it.



13. I have had a period of four days or more when my mood was so good

**Yes No** or elevated, like I was on top of the world, that it caused problems for me, or people thought I wasn't my usual self.

**Yes No** 14. I have been feeling down, blue, or depressed frequently over the past two years.

45

49

15. I have had a time when I felt very sad, blue, down, or depressed, or

**Yes No** lost interest or pleasure in my usual activities, for two weeks or more.

53

**Yes No** 16. (For women only) I get really depressed, irritable, anxious, or have mood swings in the week prior to menstruation (my period).

68

17. I am distressed about a really bad event (like seeing something that

**Yes No** was life-threatening or caused someone to die, being seriously injured or seeing someone be seriously injured, or being sexually assaulted or

molested) that I have experienced or witnessed.

72

**Yes No** 18. I'm having a hard time dealing with a stressful or unpleasant experience, or a major change in my life.

80

1. I have had very strong beliefs in something that other people thought were strange, such as any of the following:
	1. That people were conspiring against me, spying on me, or harassing me
	2. That a governmental or religious organization was following me or harassing me
	3. That someone I didn’t know, such as a celebrity, was in love with me
	4. That I had special talents or powers, or that I was famous
	5. That there was something very strange going on with my body

**Yes No** f. That someone had removed thoughts from my mind, placed

thoughts in my mind, or read my mind

1. That someone or something was controlling my movements and actions
2. That someone was sending me special messages through the TV, radio, or books
3. That I did not exist, that the world did not exist, or that the world was ending
4. That a partner was being unfaithful to me
5. That I was responsible for a disaster or serious crime and needed to be punished

82



1. I have had sensory experiences that others could not understand, such as:
	1. Hearing sounds that others couldn’t hear, such as voices or music
	2. Seeing things that others couldn’t see, such as colors, animals,

**Yes No** people, or spirits

* 1. Having unusual sensations in my body, such as a feeling of electric shocks or bugs on me
	2. Smelling odors that others could not smell, such as vomit, feces, or something rotting

84

**Yes No** 21. I avoid eating food because I think I am overweight.

92

**Yes No** 22. I often have eating "binges," in which I eat more than most people would eat, and it feels like my eating is out of control.

95

**Yes No** 23. I eat very little, have difficulty eating enough, or avoid certain foods.

100

**Yes No** 24. I have a physical health problem that makes me very worried or anxious, or requires me to do a lot to diagnose or monitor it.

103

**Yes No** 25. I often worry that I have a serious medical illness or injury, or that I am going to develop a serious medical illness or injury.

105

**Yes No** 26. I have had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions.

108

108

112

115

**Yes No** 27. I have used illegal drugs, or I have used prescription medications other than how they were prescribed more than three times.

**Yes No** 28. I have difficulty paying attention or concentrating when I need to.

112

**Yes No** 29. It often seems that I have difficulty sitting still or waiting for things.

**Yes No** 30. I have a lot of sudden movements (tics) that are hard to control, or make sounds that are hard to control.