

3. Standard Intake Questionnaire

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referral Information

Referred By:

- Psychology Today
- My website: jenniferhughesphd.com
- iTherapy
- Online Counselling Directory
- Mental Health Match
- Current or Former Healthcare Provider

Please specify (name and specialty):

- Socia Media

Please specify (e.g. Facebook, Instagram, etc.):

- Friend/family

- Other

Please specify:

Complaint

Tell me why you are seeking therapy at this time?:

Have you been in therapy for this problem before?:

If Yes, enter previous therapist(s) seen and describe what therapy was like:

What makes your primary complaint or symptoms worse?:

What helps you to feel better or get relief from your symptoms?:

Have you or a loved one ever experienced a traumatic event? If yes, please specify:

Current Symptoms

(check all that apply)

- Anxiety
- Appetite Issues
- Avoidance
- Crying Spells
- Depression
- Excessive Energy
- Fatigue
- Guilt
- Hallucinations
- Impulsivity
- Irritability
- Libido Changes
- Loss of Interest
- Nightmares

- Panic Attacks
- Racing Thoughts
- Risky Activity
- Sleep Changes
- Suspiciousness

Other Symptoms (Please describe)::

Medical History

Exercise Frequency:

Exercise Type:

Allergies:

What medications are you currently taking?:

Previous diagnoses/mental health treatment:

Previously treated by:

Previous medications:

Dates treated:

Have you ever been hospitalized for a psychiatric reason?:

If yes, please describe the reason for the hospitalization(s) and date(s) of hospitalization:

Previous medical conditions:

Previous surgeries:

Family History

Were you adopted? If yes, at what age?:

How is your relationship with your mother?:

How is your relationship with your father?:

Siblings and their ages:

Are your parents married?:

Did your parents divorce? If yes, how old were you?:

Did your parents remarry? If yes, how old were you?:

Who raised you? Where did you grow up?:

Family member medical conditions:

Family member mental conditions:

Treated with medication?:

Medications:

Educational History

Highest Grade Completed?:

Did you attend college and/or graduate school?:

Highest degree obtained?:

Religious/Spiritual Information

Do you consider yourself to be religious? If so, what is your religious affiliation? :

If not, do you consider yourself to be spiritual? If yes, in what way(s)?:

Present Situation

Work:

Are you married? If yes, specify date of marriage:

Are you divorced? If yes, specify date of divorce:

Prior marriages? If yes, how many?:

What is your sexual orientation?:

Are you sexually active?:

How is your relationship with your partner?:

Do you have child(ren)? If yes, how is your relationship with your child(ren)?:

Have you ever been arrested? If yes, when and why?:

Have you ever tried the following?

(check all that apply)

- Alcohol
- Tobacco
- Marijuana
- Hallucinogens (LSD)
- Heroin
- Methamphetamines
- Cocaine
- Stimulants (Pills)
- Ecstasy
- Methadone
- Tranquilizers
- Pain Killers

If yes to any, list frequency/dates of use:

Have you ever been treated for drug/alcohol abuse? If yes, when?:

Do you smoke cigarettes? If yes, how many per day?:

Do you drink caffeinated beverages? If yes, how many per day?:

Have you ever abused prescription drugs? If yes, which ones?:

Additional

Anything else you want Dr. Hughes to know?: