GREAT MINDS THERAPY

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Patient Questionnaire/Intake

General:

Name ________________________________ Date____________________
Address ______________________________
Home phone ___________________
Work phone ___________________
E-mail _______________________________
Referred by ____________________
Age _________________________________
Date of birth ___________________
Marital status __________________________
Educational level _______________
Occupation ____________________________
Names and ages of children_______________________________________
____
Emergency contact information ___________________________________
Explanation of how patient may be contacted by therapist ________________
____

Areas of Concern:

What issues/concerns causes you to seek treatment? Please describe.
____
____
____
____
____

Do you have any specific goals with regard to your treatment?
____
____
____

Do you have any particular concerns/fears with regard to treatment?
____
____

Psychological History:

Have you ever received mental health treatment before? ___________________
When and for how long? ____
What was the focus of treatment? _______________________________________
Name of treating therapist(s), address(es), telephone number(s)*

____

____

Have you ever been subjected to one or more psychological tests? __________
If so, by whom*? ____
Name of person(s) administered psychological tests, address(es), telephone number(s)*

____

____

Have you ever been hospitalized for mental or emotional problems? _________

When and for how long? ____
Why were you hospitalized? ____

Name of treating therapist, address, telephone number*

____

____

Are you currently taking any prescription medications? Dosage?___________

____

____

Prescribed by whom*? ____

How long have you been on the medications? __________________________
Have you ever taken any medications for a mental or emotional condition?

____

____

When and for how long?

____

Have you ever attempted suicide? _____________________________________
When? ____
Describe the circumstances that led to that attempt.

____

____

____

Are you currently having any suicidal thoughts? Please describe

____

____
____

Please describe your childhood ____

Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe.

____
____
____

Have you ever been a victim of a violent crime? Please describe

____
____

Medical History:

Have you ever been diagnosed with a serious illness? Please describe_______

____

Have you experienced any bodily or head trauma, fall, or injuries? Please describe the incident(s)

____
____

Have you had any surgeries?____
Do you have any medical conditions that may affect your mental health treatment?

____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe. _________________________________

____

Please describe your overall health today?__________________________________

Physical activities:

Do you perform any physical activities? Describe (gym, dance class, jogging, etc.)

____
____

How many times per week? Duration of each?

____

Substance Use:

Have you ever been in a 12-step program? Please describe. ____________________________

____

Do you smoke? ______ How much? ______________ For how long? ______________________
Do you drink alcohol? ________________
On average, how much alcohol do you consume in a week?_____________________________

Do you drink coffee? How many cups a day? ____________________________________
Do you currently use illegal drugs or marijuana? Please describe your use

____
Have you ever used illegal drugs or marijuana? Please describe

____

Family of Origin History

Mother's name, age, living/deceased, patient's age at the time of mother's death, description of relationship with mother ____

____
____
Father's name, age, living/deceased, patient's age at the time of father's death, description of relationship with father____

____
____
Names and ages of siblings ____
____

Other Information

Please describe your spiritual identity/orientation ________________________________
Please describe your interests/hobbies ____

____
Are you now or have you ever been involved in a lawsuit? _________________________
Please describe. ____

____
Do you have any close friends? ____Yes _____No If yes, how many?_______
How often do you see your friends?___________________________________
How would you describe your relationships?______________________________

____
Do you have other social supports?____________________________________

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested. ________________________________

____
____

*The authorization for release of confidential information will be
needed in case if any former or current therapists/psychologists/physicians have to be contacted