INTAKE QUESTIONNAIRE

This questionnaire will help me understand your situation. *If you feel uncomfortable answering any question, you may leave it blank.* If you are unsure of an answer, you may give your best estimate.

Contact Information

Name: _____

Home Address: _____

Phone: (Home) _____ (Work)_____

(Cell) _____ (Other, please specify) _____

Email: _____ (*optional*) *Please note that Dr. Heinz does not use email for emergencies or any substantial clinical matters.*

Emergency Contact: (Name) _____

(Phone) _____ (Relationship) _____

Referred by: _____

Reimbursement: Would you like to receive a monthly statement that you can forward to your insurance company to request reimbursement? **Yes** **No**

If yes, is it OK to email statements to you? **Yes** **No, please mail it to my home address**

Personal Information

1. Age: _____ 2.Date of birth: _____ 3. Gender: _____

4. Ethnicity (circle all that apply):

Caucasian	Black/African-American	Hispanic	South Asian
Middle Eastern	East Asian	Southeast Asian	Native American
Pacific Islander	Other: _____		

5. Religious background (circle one) Protestant Catholic Jewish Muslim Hindu Buddhist No Affilitation Other: _____

6. What is your sexual orientation? _____

7. Marital status ():

Single, never married	Cohabiting	Married	Widowed	Divorced	Separated

8. If you have a partner or spouse, how long have you been together? _____

9. If you have a partner or spouse, what is your spouse/partner's occupation? _____

10. If divorced, when did you divorce and how long were you married? _____

11. If you are widowed, when and how did your spouse die? _____

12. If applicable, please list names and ages of your children:

First Name	Gender/Age	Where does s/he live?	Biological?
			Y/N
			Y/N
			Y/N

13. Names of persons living in your home and your relationship to them:

First Name	Relationship	First Name	Relationship

Family/Social History

1. Mother's First Name _____ Biological parent? **Yes** **No**

Where was she born? _____

If living, age and health status: _____

If living, where does she live now? _____

If deceased, year and cause of death: _____

2. Father's First Name _____ Biological parent? **Yes** **No**

Where was he born? _____

If living, age and health status: _____

If living, where does he live now? _____

If deceased, year and cause of death: _____

3. Did your parents marry? **Yes** **No**

4. Did your parents separate or divorce? **Yes** **No** If yes, when? _____

5. With whom did you primarily live while growing up? _____

6. Siblings

First Name	Gender/Age	Occupation	Where does s/he live?

7. Where were you born? _____ 8. Where did you grow up? _____

9. Is English your first language? **Yes** **No** If no, please specify first language _____

Education and Employment History

1. Are you going to school now? **Yes** **No** (If yes) Full-time (If yes) Part-time

If yes, what are you studying? _____

2. Number of years of education completed _____

3. What is your highest degree and when did you earn it? _____

4. Did you ever leave a school you were enrolled in prior to completion? **Yes** **No**

If yes, give details:_____

5. Did you ever receive any special education services (e.g. academic tutoring, IEP, classroom

accommodations)? **Yes** **No** If yes, give details: _____

6. Are you working now? **Yes** **No** (If yes) Full-time (If yes) Part-time

7. Recent Employment history:

Type of job How long?

_____

_____

9. Are you receiving or have you ever received medical or disability benefits? **Yes** **No**

If yes, give details: _____

Current Problems and Treatment History

1. Please describe briefly what brings you in to see me.

_____

_____

_____

a. When did you start having these problems? _____

b. Have you ever had problems like this before? **Yes** **No** If yes, when? _____

2. Are you currently seeing another therapist/psychiatrist? **Yes** **No** If yes, please provide the following info:

Provider's name _____ Date treatment began_____

3. Have you previously been in therapy or counseling, including individual, group, marital or family therapy?

Yes **No** If yes, please provide the following information:

Therapist's name(s)	Date(s) of treatment	Problem for which treatment was sought	Was it helpful? (Y/N)

4. Has a health professional ever recommended hospitalization or partial hospitalization for mental or emotional difficulties or for drug or alcohol abuse? **Yes** **No**

5. Have you ever been hospitalized in an inpatient or partial hospitalization program for mental or emotional difficulties or for drug or alcohol abuse? **Yes** **No** If yes, please complete the following chart:

When were you hospitalized?	For how long?	Reasons for hospitalization or partial hospitalization	Was it voluntary? (Y/N)

6. Do you *currently* take medications to treat mental/emotional difficulties or substance abuse prescribed by a physician/psychiatrist? **Yes** **No** If yes, please complete the following chart:

Psychiatric* Medication Name	Dosage/ Frequency	When started?	Name of Prescriber	Prescribed for what symptoms?

*Later in the questionnaire, you will be asked to list medications for medical conditions.

7. Are you currently involved in any other activities to help with your symptoms (e.g., massage therapy, acupuncture, chiropractor, meditation classes)? If yes, please describe.

_____

8. Do you currently take any herbal supplements or medicines? **Yes** **No**

If yes, what do you take? _____

How often?_____ For what reason? _____

9. Please list medications you have taken *previously* to treat mental or emotional difficulties or drug or alcohol abuse: _____

_____

10. Have you ever made a suicide attempt? **Yes** **No**

11. Have you ever purposely harmed yourself (cutting, burning, or other)? **Yes** **No**

12. Do any biological relatives have any history of psychiatric, emotional and/or substance use problems?

Yes **No** If yes, which family members and what types of problems?

_____

_____

_____

Medical History

1. Do you now have, or have you had in the past, any serious, chronic or recurrent health problems or disabilities?

Yes **No** If yes, please describe:

_____

_____

2. Are you currently taking medications for any physical health problems? **Yes** **No**

If yes, please complete the following chart.

Medication Name	When Started?	Name of Prescriber	Prescribed for what symptoms?

3. List dates of any hospitalizations for physical problems:

Date Problem

_____

_____

4. When was your last physical examination by a physician? _____

What was the outcome? _____

5. Do you exercise? **Yes** **No** If yes, how often? _____

Substance Use

1. Do you smoke cigarettes? **Yes** **No** If yes, how much do you smoke? _____ cigarettes per _____

2. Do you drink caffeinated beverages? **Yes** **No** If yes, how many cups daily? _____

3. Have you ever used any drugs or medications other than as prescribed? (Including prescribed drugs (e.g. valium), marijuana, amphetamines, cocaine, opiates, MDMA (e.g., Ecstasy), inhalants, or others): **Yes** **No**

Are you currently using? **Yes** **No** If yes, please complete the following:

Type Frequency/Amount Duration How taken

_____

_____

_____

4. If you have used any substances listed above, do you feel they have caused any problems in your work, school or relationships? **Yes** **No**

If yes, please explain: _____

_____

5. Do you drink alcohol? **Yes No** If yes, please answer the following questions:

How much alcohol do you drink? _____ drinks per _____

Have you ever felt you ought to cut down on your drinking? **Yes No**

Have people annoyed you by criticizing your drinking? **Yes No**

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

Yes No

Do you feel your drinking has caused any problems in your work, school or relationships? **Yes No**

If yes, please explain: _____

_____

Have you ever been treated for drug or alcohol abuse? **Yes No**

If yes, please describe the provider/program, give dates and describe the outcome.

_____

_____

Abuse/Trauma

1. Have you ever had a physical fight with anyone, including your spouse or partner (including throwing things, hitting, shoving, etc.)? **Yes No**

2. Did you ever have sexual contact with someone that you did not want? **Yes No**

3. Have you experienced or witnessed any traumas (events that felt life-threatening)? **Yes No**

4. Have you experienced physical or sexual abuse or assault? **Yes No**

Other Background

1. Have you ever been involved in a lawsuit? **Yes No**

If yes, please describe the circumstances and give dates:

_____

2. Have you ever been arrested? **Yes No**

If yes, please describe the circumstances and give dates:

_____

3. Have you experienced any particular sources of stress in the last year? **Yes** **No**

If yes, please explain:

_____

_____

4. Are there any other health care professionals (e.g. physicians, psychotherapists) who have information that might help in your treatment? **Yes** **No**

If yes, please provide that person's name and contact information:

_____

5. If there is any other information that would be helpful for me to know, please explain:

_____

_____

_____

_____

_____ _____

Signature Date