Psychological History Questionnaire and Intake

Name: Date:

Patient's Date of Birth: Gender:

Handedness: Ethnicity:

Completed by (if different): Legal relationship to patient:

Why are you initiating this evaluation/treatment? Describe pertinent facts, such as date of problem onset, developmental patterns, goals for evaluation/treatment.

Is there any history of psychological testing/treatment?

[ ] Yes [ ] No

If yes, by whom?

Dates of testing/treatment:

Testing/treatment outcome:

Are there any litigation and/or administrative issues related to this evaluation/treatment either currently or expected in the future?

[ ] Yes [ ] No

If yes, please describe:

Presenting Problems/Symptoms

1. Please describe the problems that are of most concern to you:

2. Please describe when and how you first became aware of these difficulties and whether they have changed over time (better or worse):

3. Please describe current sources of stress (school problems, alcohol/drug use, losses, financial pressures, type of relationship problems, etc.):

4. Please describe any loss of consciousness or other head injury:

5. Describe any history of suicidal thoughts or attempts:

6. Describe any history of homicidal thoughts or attempts:

7. Who is the current physician(s):

Social History

List all people living in the same household:

Name	Age	Relationship	Currently in same household

1. Describe joint activities (hobbies, leisure, community):

2. Describe relationships with siblings:

3. Describe the history of friends at school/work:

4. Describe the history of friends in the community:

5. Describe history of friends online:

6. Describe any significant losses of relationship:

Medical History

Describe general health status/issues:

Please list all current medications:

Medication/Prescribed by:	Current dosage	Length of time on medication	Reason

Please list all past medications:

Medication/Prescribed by:	Current dosage	Length of time on medication	Reason

Please list illnesses, surgeries and hospitalizations:

Illness/Condition	Dates	Treatment Outcome

Please list any neurological test such as MRIs, CT's EEGs, etc.

Test	Date	Result

Health Problem Checklist:

Patient Problem	Check Problem Areas	Describe Problem
Loss of sensation		
Paralysis or weakness		
Loss or change in sense of smell		
Loss or change in hearing		
Loss or change in vision		
Dizziness or fainting spells		
High blood pressure		
Attention Problems		
Depression		
Bipolar		
Anxiety		
Seizure		
Diabetes		
Cancer		
Allergies		
Other:		

Family History Medical Problems Checklist:

Problem	Check Problem Areas	Family members with problem
Learning problems		
Attention problems		
Depression		
Anxiety		
Bipolar		
Seizures		
Obsessive-Compulsive		
Hypertension		
Heart disease		
Stroke		
Cancer		
Multiple Sclerosis		
Parkinson’s		
Alzheimer’s		
Alcoholism		
Drug addiction		
Other:		

Parent History

Describe marital history:

Describe current marital relations:

Biological father:

Birth date:

Birthplace:

Ethnic origins:

Occupation:

Education:

Biological mother:

Birth date:

Birthplace:

Ethnic origins:

Occupation:

Education:

If different, parenting father:

Birth date:

Birthplace:

Ethnic origins:

Occupation:

Education:

If different, Parenting mother:

Birth date:

Birthplace:

Ethnic origins:

Occupation:

Education:

Describe any other relevant parenting information (parenting methods/practices etc.):

Developmental History

Birth weight: Birth Length: APGAR score:

1. Describe any problems during pregnancy or delivery:

2. Describe any maternal substance use/abuse during pregnancy:

3. Describe any changes in primary caregivers during the first three years of life:

4. Have there been extended separations from parent(s):

5. Describe any frightening/traumatic experiences?

6. Describe any loss of significant relationship

7. Describe any episodes of struggle adjusting to changes in life circumstances?

Educational History

School attended	City/State	Grades attended	Grades achieved	Degrees achieved

1. List all languages spoken in the household in order of frequency:

2. Describe any problems during pre-school, kindergarten, or first grade:

3. Describe the patient's academic strengths and weaknesses:

4. Describe any history of social problems with peers, family members, teachers, etc.:

5. Describe any history of tutoring:

6. Describe any history of significant academic problems (repeated grade, special education courses):

7. Describe involvement in extracurricular activities (artistic, academic, athletic)?