INTAKE QUESTIONNAIRE

Today's Date: _____

Name of Patient _____ Age_____

Primary Care Physician_____

Whom do we thank for referring you to our office._____

Presenting Problems:

In the space provided below, list your problems or other needs we may assist you with. Please include details:

_____
_____
_____

Medication Use: T

List below all current and past medications that have been prescribed for you:

Type Amount Frequency of Use

_____
_____
_____

Please circle any of the following problems which pertain to you:

Anxiety	Suicidal Thoughts	Sleep Changes	Alcohol Use
Nervousness	Aggressive Thoughts	Inability to Sleep	Drug Use
Stress	Paranoia	Excessive Sleep	Headaches
Fears	Hallucinations	Daytime Napping	Stomach Aches
Depression	Hearing Voices	Tiredness	Dizziness
Unhappy	Seeing Visions	Appetite Changes	Sexual Problems
Lonely	Irritability	Weight Gain	Confusion
Guilt	Mood Swings	Weight Loss	Poor Memory

How long have these problems existed? In days, weeks, months or years?