Family Connections Counseling Services, LLC
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PATIENT INTAKE QUESTIONNAIRE

Patient Name: _____ Date of Appointment: _____

Date of Birth: _____ Age: _____ _____ Male ____ Female

Diagnosis _____ CPT Code: _____

Who brought the patient to the appointment today? _____

Name of person answering the questionnaire: _____

Relationship to the patient: _____

COMPLAINT

Please describe patient's current complaint: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

At what age did this begin? _____

How does this limit the patient from doing daily activities? _____

_____

_____

_____

BEHAVIOR

Please describe any behavioral problems the patient is having at home:

_____
_____
_____
_____
_____
_____
_____
_____

Behavior/Temperament

Please check those that apply to the patient:

___ Gets excited easily during play
___ Has a short attention span
___ Lacks self-control
___ Seems unhappy most of the time
___ Withholds affection
___ Hides feelings
___ Has fears (Explain: _____)
___ Overly energetic / very active
___ Does things without thinking
___ Overreacts when faced with a problem
___ Seems uncomfortable meeting new people
___ Requires a lot of attention
___ Cannot calm down
___ Does not follow directions

MEDICAL HISTORY

Pregnancy/Birth Information

Was the patient's mother under a doctor's care during the pregnancy? ___ Yes ___ No
Did the patient's mother experience any complications during her pregnancy? ___ Yes ___ No
If yes, please explain:

_____
_____
_____
_____

What medications were taken during the pregnancy?

_____
_____

Was alcohol or drugs used during pregnancy? ___ Yes ___ No If yes, please list those used:

_____
_____

Was the patient born in a hospital? ___ Yes ___ No If no, where? _____

Length of pregnancy: _____ weeks Birth Weight: _____lbs. _____ oz.

Length of labor: _____ hours

Were there complications during the birth? If yes, please explain:
_____
_____

Length of stay in hospital: _____

Developmental Milestones

Started walking at age _____

Started talking (putting words together) at age _____

Potty trained at age _____

Medical History

Patient's physician: _____

Does the patient have any chronic health conditions (asthma, high blood pressure…)?
If yes, please explain: _____
_____
_____
_____

Has the patient ever experienced a head injury? ___ Yes ___ No
If yes, please explain: _____
_____
_____

Has the patient ever had a seizure? ___ Yes ___ No If yes, date of last seizure? _____

Please list all medications the patient currently takes on a regular basis as well as medications they have taken in the past:

Name of Medication	Dosage	Date started taking the medication	Is it effective?	Side Effects

Name of Medication	Dosage	Date started taking the medication	Is it effective?	Side Effects

Who prescribes medication: _____

Has the patient ever been prescribed medication they decided not to take? ____ Yes _____ No
If yes, please list medications and reason why patient did not take the medication: _____
_____
_____
_____

Hospitalizations for Medical Reasons

Date	Hospital Name & Doctor Name	Reason for Hospitalization	Length of Stay

PSYCHIATRIC/SUBSTANCE ABUSE HISTORY

Psychiatric History

Has the patient ever been involved in psychological counseling or therapy? ____ Yes ____ No
If yes, please list details: _____
_____
_____

Type of counseling (For example… intensive in-home, adult support services, day treatment, outpatient counseling, RBHA, school counseling)	**Agency Name**	**Counselor's Name**	**Start Date and End Date**	**Reason for Seeking Counseling**

Has the patient ever been hospitalized for mental health reasons? ___ Yes ___ No

If yes, please list details below:

Reason for Hospitalization	**Name of Hospital**	**Date Admitted**	**Length of Stay**

Has the patient ever been verbally, mentally, physically, or sexually abused? ___ Yes ___ No
If yes, please explain:
_____
_____
_____
_____

Has the patient ever witnessed abuse? ____ Yes ____ No If Yes, please explain: _____
_____
_____

Does the patient hear voices that others do not hear? ___ Yes ___ No If yes, please describe what these voices say:
_____
_____

Does the patient see things that others do not see? ___ Yes ___ No If yes, please describe what is seen:

_____
_____

Has the patient ever attempted to hurt themselves or others? ___ Yes ___ No If yes, please provide details including date, action, and whether hospitalization occurred: _____
_____
_____
_____

Does the patient have problems when a change in their routine occurs? ____ Yes ____ No

Has the patient ever put themselves or others in dangerous situations? ____ Yes ____ No
If yes, please explain: _____
_____
_____
_____

Does the patient have problems with aggressive behavior (verbal, physical)? ____ Yes ____ No
If yes, please explain frequency and with whom (peers, teachers, parents): _____
_____
_____
_____
_____

Substance Use/Abuse

Does the patient have a history of substance/alcohol abuse? ___ Yes ___ No If yes, please list details in the chart below.

Is the patient currently using illegal drugs and/or alcohol? ___ Yes ___ No
If yes, please explain:

Name of drug/alcohol	Last used?	How often does the patient use?	Has the patient ever sought treatment for this use? / date and location

EDUCATION HISTORY

Current grade: _____ Current School Attending: _____

What type of grades is the patient currently earning in school? _____

Does the patient experience behavioral problems in school? ___ Yes ___ No If yes, explain:
_____
_____
_____
_____

Has the patient ever been suspended from school or from the bus? ___ Yes ___ No If yes, please explain why:
_____
_____
_____
_____

Approximately how many days have the patient missed school this school year? _____

Is the patient currently in special-education classes? ___ Yes ___ No If yes, what grade did they start special education classes? _____

Does the patient have an IEP? ____ Yes ____ No

Does the patient have a 504 Plan? ___ Yes ___ No

How many schools has this patient attended? _____ Reason for changes in schools?
_____
_____
_____

If no longer attending school, what is the highest grade the patient completed? _____

Graduation Year: _____ Type of Diploma received: _____

If the patient dropped out of school, please explain why: _____
_____
_____
_____

Has the patient ever been retained a grade in school? If yes, when and why? _____
_____
_____

Does the patient have difficulty with reading? ___ Yes ___ No

Does the patient have difficulty with math? ___ Yes ___ No

Does patient have trouble getting homework completed? ___ Yes ___ No If yes, explain:
_____
_____

Does patient experience behavioral problems in school? ___ Yes ___ No If yes, explain:
_____
_____
_____
_____

Suspensions: when/why
_____
_____
_____

Court/school involvement: _____
_____

JOB HISTORY

Is the patient currently employed? ___ Yes ___ No

Name of patient's current employer (if employed) _____

Current job responsibilities _____

How long has the patient been in the current job? _____

Previous job history:

Name of Employer	Dates Employed	Job Title/Duties	Reason for Leaving

Arrive timely? _____

Transportation to/from job _____

SOCIAL HISTORY

Does the patient have problems relating to peers? ___ Yes ___ No If yes, please explain:
_____
_____

Does the patient have friends in the neighborhood? ____ Yes ___ No If No, please explain:
_____
_____

Does the patient fight frequently with peers? ___ Yes (_____Verbally _____Physically) ___ No
If yes, please explain:
_____
_____

Does the patient prefer to be alone? ___ Yes ___ No

What activities does the patient enjoy (sports?): _____
_____
_____

Has the patient's interest in these activities declined recently? ___ Yes ___ No If yes, please explain: _____
_____
_____

What is the patient's current sleep pattern? _____
_____

What time does patient go to bed? _____

What time does the patient wake up? _____

How many hours on average does patient receive of uninterrupted sleep? _____

Does patient take naps? ___ Yes ___ No

Does patient have any problems with appetite? ___ Yes ___ No If yes, please explain:
_____

Is patient on any sleep medication? ___ Yes ___ No If yes, what:_____

Has patient had a sleep study? ___ Yes ___ No

Where? _____

When? _____?

Results of study? _____

LEGAL HISTORY

Has the patient ever been involved with the legal system? ___ Yes ___ No
If yes, please provide details below:

Charge	Date of Charge	Outcome (time served, dismissed, community service…)	Describe what happened

FAMILY HISTORY

Patient's mother's name: _____ Age: _____

Patient's father's name: _____ Age: _____

Is the patient closer to one parent than the other? ___ Yes ___ No If yes, which? _____

Has the patient ever experienced any parental separations, divorces, or death? ___ Yes ___ No
If yes, please explain:
_____
_____
_____

Who does the patient currently live with? Please list everyone that lives in the home and their relationship to the patient:
_____
_____
_____

If patient is a minor and parents are separated or divorced, who has custody of the patient?
_____

How often does the other parent see this patient? (check one)

___ Weekly or more often ___ Once or twice a month ___ Few times a year ___ Never

Please list all Brothers/Sisters of the patient

Brother or Sister	Age	Living at home? If no, where do they live?	How do they get along with the patient?	Any health problems or special needs?

Have any family members of the patient had any of the following? If yes, please specify the family member's relationship to the patient.

Family Member's Relation To Patient (mother, father, sister, aunt)	Health Concern
	Alcohol/Drug abuse
	Behavior Problems
	Emotional Problems
	ADHD
	Bipolar
	Depression

Family Member's Relation To Patient (mother, father, sister, aunt)	Health Concern
	Anxiety
	Schizophrenia
	Anger management problems
	Reading problems
	Learning disability
	Speech problems

CLINICIAN'S IMPRESSIONS/FINDINGS

_____

_____

_____

_____

_____

_____

Person completing this form: _____

Signature/Title