Amen Clinics, Inc. Adult Intake Questionnaires

In order for us to be able to fully evaluate you, please fill out the following intake form and questionnaires to the best of your ability. We realize there is a lot of information and you may not remember or have access to all of it; do the best you can. If there is information you do not want in your medical chart it is ok to refrain from putting it in this information. Thank you!

PATIENT IDENTIFICATION

Name _____ First Appointment Date _____
Birth Date _____ Age _____ Sex _____
Religion _____ Marital Status _____
Race _____ Children _____
Address _____ City _____ State ____ Zip _____
Home Phone # _____ Work # _____
Who are you currently living with? _____

REFERRAL SOURCE _____ Address _____
Phone #_____ Fax # _____ Do we have your permission to release information to the referring professional when it is appropriate? Yes ____ No _____

MAIN PURPOSE OF THE CONSULTATION (Please give a brief summary of the main problems)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

WHY DID YOU SEEK THE EVALUATION AT THIS TIME? What are your goals in being here?

_____
_____
_____

PRIOR ATTEMPTS TO CORRECT PROBLEMS/PRIOR PSYCHIATRIC HISTORY
(Please include contact with other professionals, medications, types of treatment, etc.)

_____
_____

Name:_____

MEDICAL HISTORY

Current medical problems/medications:_____
_____
Current supplemets/vitamins/herbs:_____
Past medical problems/medications: _____
_____
Other doctors/clinics seen regularly: _____
Any history of head trauma? (describe): _____
Ever any seizures or seizure like activity? _____
Prior hospitalizations (place, cause, date, outcome): _____
Prior abnormal lab tests, X-rays, EEG, etc: _____
Allergies/drug intolerances (describe): _____
Present Height _____ *Present Weight* _____

CURRENT LIFE STRESSES (include anything that is currently stressful for you, examples include relationships, job, school, finances, children)_____
_____
_____

Prenatal and birth events: Your parents attitude toward their pregnancy with you _____
Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc_____
Any birth problems, trauma, forceps or complications?: _____

Sleep behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)
_____
_____

School History: Last grade completed _____ Last school attended _____
Average grades received _____ Specific learning disabilities _____
Learning strengths _____
Any behavior problems in school? _____
What have teachers said about you _____
Please bring school report cards and any state, national or special testing that has been performed.

Employment History: (summarize jobs you've had, list most favorite and least favorite)
_____
_____
Any work-related problems? _____
What would your employers or supervisors say about you? _____

Military History? _____

Ever Any Legal Problems? _____

Sexual history: (answer only as much as you feel comfortable)
Age at the time of first sexual experience: _____ Number of sexual partners: _____
Any history of sexually transmitted disease? _____ History of abortion? _____
History of sexual abuse, molestation or rape? _____
Current sexual problems?_____

Name:_____

Alcohol and Drug History: (Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel; what benefit you got from them.). These include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP. _____

_____

_____

_____

Ever experience withdrawal symptoms from alcohol or drugs? _____
Has anyone told you they thought you had a problem with drugs or alcohol? _____
Have you ever felt guilty about your drug or alcohol use? _____
Have you ever felt annoyed when someone talked to you about your drug or alcohol use? _____
Have you ever used drugs or alcohol first thing in the morning?_____
Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate) _____
Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew) _____

FAMILY HISTORY

Family Structure (who lives in your current household, please give relationship to each):

_____

_____

Current Marital or Relationship Satisfaction_____

_____

Significant Developmental Events (include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.)_____

_____

_____

History of Past Marriages _____

Natural Mother's History: age_____ outside work _____
School: highest grade completed _____
Learning problems _____ Behavior problems _____
Marriages _____
Medical Problems _____
Childhood atmosphere (family position, abuse, illnesses, etc)_____

_____

Has mother ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____

_____

Mother's alcohol/drug use history _____
Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

_____

_____

Name:_____

Natural Father's History: age_____ outside work _____
School: highest grade completed _____
Learning problems _____ Behavior problems _____
Marriages _____
Medical Problems _____
Childhood atmosphere (family position, abuse, illnesses, etc)_____
_____
Has father ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____
_____
Father's alcohol/drug use history _____
Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)
_____
_____

Siblings (names, ages, problems, strengths, relationship to patient) _____
_____
_____
_____

Children (names, ages, problems, strengths) _____
_____
_____

Cultural/Ethnic Background _____
_____

Describe your relationships with friends _____
_____

Describe yourself _____
_____

Describe your strengths _____
_____