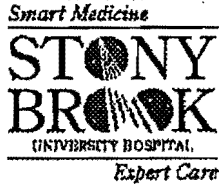


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**ADULT OUTPATIENT PSYCHIATRY
INTAKE QUESTIONNAIRE**

DATE: _____

NAME OF PATIENT _____ AGE _____ DATE OF BIRTH _____

TELEPHONE: _____ (HOME) _____ (OFFICE) SEX M () F ()

ADDRESS: _____
(STREET)

(CITY)

(STATE)

(ZIP CODE)

SOCIAL SECURITY # _____

PERSON OR AGENCY WHO REFERRED YOU HERE: (Mark one applicable)

() Self () Family () Friend () Clergy () Employer

() Physician / Healthcare Provider: Name & Specialty _____

() Court: Name of Court/Probation Officer _____

() Other Agency _____ () Others _____

(Please specify)

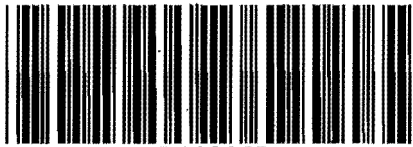
() Inpatient Medical () Inpatient Psychiatric () Emergency Room

ETHNIC BACKGROUND: () White () African-American () Asian () Hispanic/Latino
() Native American () Other _____

RELIGION: () Catholic () Protestant () Jewish () Moslem () None
() Other _____

**PLEASE LIST ANY PROBLEMS: (in your own words in order of importance) WITH WHICH YOU
WOULD LIKE HELP AT THIS TIME:**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____



**ADULT OUTPATIENT PSYCHIATRY
 INTAKE QUESTIONNAIRE**

PLEASE INDICATE HOW YOUR PROBLEMS ARE AFFECTING THE FOLLOWING AREAS:

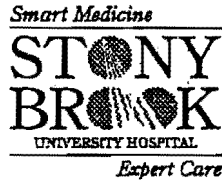
Please assess how current symptoms have affected the level of impairment in the following categories and indicate anticipated impairment at discharge.

IMPAIRMENT LEVEL

CATEGORY	NO IMPAIRMENT	MILD IMPAIRMENT	MODERATE IMPAIRMENT	MARKED IMPAIRMENT	EXTREME IMPAIRMENT	ANTICIPATE IMPAIRMENT DISCHARGE
Marriage Family Relationships	1	2	3	4	5	
Job/School Performance	1	2	3	4	5	
	Disability Leave _____	Job Jeopardy _____				
Friendships/ Peer Relationships	1	2	3	4	5	
Financial Situation	1	2	3	4	5	
Hobbies/ Interests	1	2	3	4	5	
Play Activities	1	2	3	4	5	
Physical Health	1	2	3	4	5	
Activities of Family (personal hygiene, bathing, etc.)	1	2	3	4	5	
Eating Habits	1 Weight Loss lbs	2 Weight Gain lbs	3 Current Weight	4 Height	5	
Sleeping Habits	1 Difficulty Falling Asleep _____	2 Difficulty Staying Asleep _____	3 Early Morning Awakening	4	5	
Sexual Functioning	1	2	3	4	5	
Ability to Concentrate	1	2	3	4	5	
Control your Temper	1	2	3	4	5	
					SCORE:	



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ADULT OUTPATIENT PSYCHIATRY INTAKE QUESTIONNAIRE

WHAT TYPE(S) OF HELP DO YOU THINK WOULD BE MOST HELPFUL TO YOU:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

EDUCATION: (Circle highest grade completed)

Elementary 1 2 3 4 5 6 7 8

High School 9 10 11 12

College 1 2 3 4 5

MARITAL STATUS: (check)

- Never married
- Married Once
- Married more than once
- Divorced
- Widowed
- Other

If currently married, how satisfied are you with your current marital relationship:

- Very
- Fairly
- Poor

OCCUPATIONAL HISTORY: Current Employment Status

- Currently Employed
- Self Employed
- Other Employed
- Unemployed
- Student
- Homemaker
- Unable to work

OCCUPATION _____

EMPLOYER _____

Length of time on present job _____

Longest period of time you held a job:

From _____ To _____

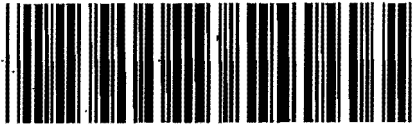
Number of jobs in the last 5 years _____

Has illness or injury affected your ability to work? Yes _____ No _____

- Totally unable to function
- Frequent absence/hospitalization
- Minor problems
- No problems at present

How satisfied are you with your current employment status?

- Very
- Fairly
- Poorly



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STONY BROOK

UNIVERSITY HOSPITAL

Expert Care

ADULT OUTPATIENT PSYCHIATRY INTAKE QUESTIONNAIRE

HOUSEHOLD COMPOSITION: PLEASE LIST ALL PEOPLE LIVING WITH YOU IN YOUR HOUSEHOLD.

RELATIONSHIP	FIRST NAME	LAST NAME	AGE	OCCUPATION/ GRAD

PAST PSYCHIATRIC HISTORY:

Inpatient Treatment: Number of previous psychiatric hospitalizations: _____

Please list all hospitalizations beginning with the most recent:

Hospital: _____

Dates: _____

Reason: _____

Medications: _____

Hospital: _____

Dates: _____

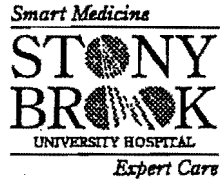
Reason: _____

Medications: _____

(For additional hospitalizations please continue on back of last page)



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ADULT OUTPATIENT PSYCHIATRY INTAKE QUESTIONNAIRE

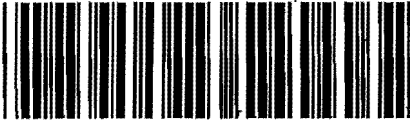
FAMILY HISTORY: Please list all family members of your immediate family (Parents, Step- Parents, Spouse, Brothers, Sister and Children)

NAME	AGE	HEALTH	MEDICAL & PSYCHIATRIC CONDITIONS	OCCUPATION/ SCHOOL GRADE	IF DECEASED AGE/CAUSE OF DEATH
Father					
Mother					
Sibling 1					
Sibling 2					
Sibling 3					
Sibling 4					
Children 1					
Children 2					
Children 3					
Children 4					

PLEASE EXPLAIN ANY SIGNIFICANT MEDICAL, PSYCHIATRIC CONDITION INCLUDING EMOTIONAL UPSET, ALCOHOLISM, SEXUAL OR LEGAL PROBLEMS:

BEFORE THE AGE OF 16 DID YOU EXPERIENCE PARENTAL DEATH, DIVORCE OR PROLONGED SEPARATION FROM FAMILY? (greater than 6 months)

YES NO



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ADULT OUTPATIENT PSYCHIATRY INTAKE QUESTIONNAIRE

HAVE YOU EVER USED DRUGS OTHER THAN PRESCRIBED BY A DOCTOR:

() YES () NO

SUBSTANCE	CURRENT	PAST	NUMBER OF TIMES IN A WEEK
NICOTINE			
COFFEE			
MARIJUANA			
BARBITURATES			
AMPHETAMINES			
COCAINE			
HALLUCINOGENS			
NARCOTICS			
OTHER			

HOW OFTEN DO YOU DRINK ALCOHOLIC BEVERAGES CURRENTLY: (PLEASE CHECK)

- () Never (less than one a week)
- () Between once a month and once a year
- () Between once a week and once a month
- () About once a week
- () Two to five times a week
- () Almost every day

HOW MANY DRINKS DO YOU USUALLY HAVE ON DAYS YOU DRINK? _____

HAVE YOU EVER HAD A DRINKING PROBLEM IN THE PAST? () YES () NO

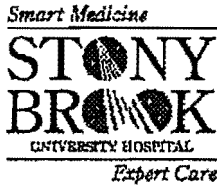
HAVE YOU EVER BEEN IN DETOX OR REHABILITATION PROGRAM? () YES () NO
IF YES PLEASE LIST:

PLACE	TYPE	DATES

(IF ADDITIONAL SPACE IS NEEDED PLEASE CONTINUE ON BACK OF LAST PAGE)



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**ADULT OUTPATIENT PSYCHIATRY
INTAKE QUESTIONNAIRE**

PREVIOUS OUTPATIENT TREATMENTS:

PLACE	THERAPIST	TYPE OF THERAPY	DATE

(IF ADDITIONAL SPACE IS NEEDED PLEASE CONTINUE ON BACK OF LAST PAGE)

WHAT PSYCHIATRIC MEDICATIONS (IF ANY) HAVE YOU BEEN ON IN THE PAST?

MEDICAL PROBLEMS _____

PLEASE LIST YOUR CURRENT MEDICATIONS: _____

ALLERGIES: _____

MEDICAL ILLNESSES _____ **DATES:** _____

_____ **DATES:** _____

_____ **DATES:** _____

MEDICAL RELATED HOSPITALIZATIONS AND SURGERIES: _____

Resident Initials: _____ **Date** _____

Attending Physician Initials: _____ **Date** _____



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ADULT OUTPATIENT PSYCHIATRY INTAKE QUESTIONNAIRE

PLEASE LIST ADDITIONAL HOSPITALIZATIONS CONTINUED FROM PAGE 4:

Hospital: _____

Dates: _____

Reason: _____

Medications: _____

Hospital: _____

Dates: _____

Reason: _____

Medications: _____

PLEASE LIST ADDITIONAL DETOX OR REHABILITATION PROGRAMS CONTINUED FROM PAGE 6:

PLACE	TYPE	DATES

PREVIOUS OUTPATIENT TREATMENTS CONTINUED FROM PAGE 7:

PLACE	THERAPIST	TYPE OF THERAPY	DATE