INTAKE EVALUATION

Name_____ DOB_____

Age_____ Gender_____ Height_____ Weight_____ Ethnic Background_____

Email_____ May I email you? Y___ N___

Primary Care Physcian_____ PCP Phone_____

May I contact your PCP on your behalf? Y____ N_____

Relationship Status:

Single__Married__Divorced__Widowed___Separated__Partner___

Do you have children Y__ N__ Names and Ages (including adult children)

_____

With whom do you live?

_____

Current Occupation:

_____

Please check to the extent that following is a problem for you:

0-none 1-slight 2-some 3-moderate 4-severe

Depression	0	1	2	3	4
Sleep Difficulties	0	1	2	3	4
Weight Change	0	1	2	3	4
Loss of Pleasure	0	1	2	3	4
Decreased Libido	0	1	2	3	4
Sexual Dysfunction	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Anger/Irritability	0	1	2	3	4
Feeling Slowed Down	0	1	2	3	4
Restlessness	0	1	2	3	4
Fatigued	0	1	2	3	4
Distracted	0	1	2	3	4
Anxious	0	1	2	3	4
Obsessions	0	1	2	3	4
Compulsions	0	1	2	3	4
Nightmares	0	1	2	3	4
Social Anxiety	0	1	2	3	4
Thoughts of Self-Harm	0	1	2	3	4
Thoughts of Harming Others	0	1	2	3	4
Low Self-Esteem	0	1	2	3	4

Hallucinations	0	1	2	3	4
Delusions/Paranoia	0	1	2	3	4
Panic Attacks	0	1	2	3	4
Racing Thoughts	0	1	2	3	4
Headaches	0	1	2	3	4
Physical Pain	0	1	2	3	4
Drinking/Substance Abuse	0	1	2	3	4
Health Problems	0	1	2	3	4
Job/School Problems	0	1	2	3	4
Family/Relationship Problems	0	1	2	3	4
Physical Appearance Problems	0	1	2	3	4
Financial Problems	0	1	2	3	4

In general, how long have you been experiencing the above symptoms?

1wk__1Mo__6Mo__1Yr__More __

Childhood:

Mother's Age___ or age at death____ Year Died___ Cause of Death_____ Mom's Occupation while you were a child_____

Current Relationship: Excellent___Good___Fair___Poor___

Relationship during childhood: Excellent___Good___Fair___Poor___

Father's Age___ or age at death___Year Died___Cause of Death_____Dad's Occupation while you were a child_____

Current Relationship: Excellent___Good___Fair___Poor___

Relationship during childhood: Excellent___Good___Fair___Poor___

Siblings: Names, Ages, Relationship Quality:

_____

_____

Describe your childhood: Happy___Fairly Happy___Unhappy____Very Unhappy___

What did you do for fun/activities?_____

In what city and state were you raised?_____

To your knowledge have you ever been bitten by a tick? Y___N___

If yes did you have a Erythema Migrans Rash (Bull's Eye)? Y___N___

(If yes, please ask for other questionnaire)

Religion(if any)_____

Education:

What was the last grade you complete?(please circle)

GED/HS Diploma/Some College/TradeSchool/Associate's Degree/Bachelor's Degree/Master's Degree/Post-

Master's Degree/Doctorate/Speciality (ex.JD, MD, DO, etc)

What name(s) of school did you attend?_____

Major of study_____

Are you in school now? For What? _____

Military Service_____Branch_____Years_____

Are you married? _____ For how long?_____

Previously Married?_____ For how long?_____

What employment have you done in the past?_____Do you like your current Job?

_____

List Allergies, Serious Accidents, Hospitalizations and Year:

_____

_____

Have you ever:

1. Been though Psychotherapy/Counseling before?Y___N___
2. Been a patient in a mental hospital? Y___N___
3. Attempted Suicide? Y___N___
4. Been Physically assaulted/abused? Y___N___
5. Been Sexually assaulted/abused? Y___N___
6. Been treated for drug/alcohol abuse? Y___N___

Does anyone in your family have: mental illness? Y___N___ Substance Abuse?Y___N___

Have you ever been in trouble with the law (including DUI/DWI)? Y___N___

Are you currently taking meds? Y___N___ is so list kind and

dose_____

Do you drink Caffeine? Y___N___ How much?

Do you drink Alcohol? Y___N___ How much?

Use Cannabis? Y___N___ How much?

Smoke Cigarette/Cigars/Pipe? Y___N___How Much?

Have you ever used:

PCP/LSD/Mushrooms

Cocaine/Methamphetamines

Sedatives(Benzodiazepines/Barbiturates

Opiates(Morphine/Heroine/Codine)

Abused Pills/Sniffed or Huffed Glue or Chemicals

Anything else I should know?_____