THE RETREAT AT PONTE VEDRA BEACH

ADULT INTAKE QUESTIONNAIRE

General Information:

First Name | Middle | Last | Date of Birth

Primary Home Address | City | State | Zip

Emergency Contact Name | Phone

Address | City | State | Zip

Primary Care Provider | Phone

Address | City | State | Zip | Fax

Current Place of Employment:

Name | Position | Length of time Employed

Address | City | State | Zip

Phone

FAMILY INFORMATION

Father's Name: _____ Age: _____ Highest Degree Attained in School:_____

Biological ( ) Adoptive ( ) Step ( ) Foster ( ) Current Occupation:_____

Living in City/State: _____, _____

Mother's Name: _____ Age: _____ Highest Degree Attained in School:_____

Biological ( ) Adoptive ( ) Step ( ) Foster ( ) Current Occupation:_____

Living in City/State: _____, _____

CHILDREN IN THE HOME:

Name: _____ AGE: _____ GRADE: _____

Name: _____ AGE: _____ GRADE: _____

Name: _____ AGE: _____ GRADE: _____

OTHERS LIVING IN THE HOME: AGE RELATIONSHIP TO YOU:

Name: _____ AGE: _____
Relationship: _____
Name: _____ AGE: _____
Relationship: _____
Name: _____ AGE: _____
Relationship: _____

MARITAL STATUS:

Current: Date of Marriage: _____
Status: Married:_____ Separation:_____ Divorce:_____

Prior: Married to _____ Date of Marriage: _____
Status: Separation:_____ Divorce:_____

Prior: Married to _____ Date of Marriage: _____
Status: Separation:_____ Divorce:_____

OTHER TREATING CLINICIANS:

Name: _____Practice: _____
Address _____ _____
Phone # ( ) _____ - _____ Fax # ( ) _____ - _____

Name: _____Practice: _____
Address _____ _____
Phone # ( ) _____ - _____ Fax # ( ) _____ - _____

REFERRED BY:

Name: _____Practice: _____
Address _____ _____
Phone # ( ) _____ - _____ Fax # ( ) _____ - _____

REASON FOR BEING HERE AT THIS TIME, CURRENT PROBLEMS: What brings you here? Please briefly describe your current concerns or problems starting with the most serious.

ONSET: How long ago did the problems begin? Was there a precipitant? Were there any major stresses happening in your life or family at the time the problems began?

TREATMENT: What kinds of interventions have been tried? Have you tried medications, seen other therapists, used any "non-traditional" treatments?

RELATIONSHIP STRESSORS: Describe what effects the problems have had on family relationships and family functioning.

WORK STRESSORS: Describe your work performance. Are there any problems?

COLLEAGUE STRESSORS: Describe your relationships with peers/colleagues. Have your concerns/ problems affected these relationships?

LIST ALL CURRENT MEDICATIONS, VITAMINS, ADDITIVES, HERBAL SUPPLEMENTS

Name	Dose	Reason/Purpose	Result/Effect

List side effects, improvements, preferences regarding medications

PAST PSYCHOLOGICAL OR PSYCHIATRIC PROBLEMS

HAVE YOU EVER BEEN TREATED FOR ANY OTHER PSYCHOLOGICAL OR PSYCHIATRIC PROBLEMS AT ANY OTHER TIME? Please describe other mental health problems and what interventions have been made. What have been the results of these interventions?

Prior Diagnosis:	Age/Year:	Intervention(s):	Result:

PAST MENTAL HEALTH PROVIDERS

Provider	Credentials	Specialty	Dates of Service

PAST AND PRESENT MEDICAL HISTORY

How is your general health currently?

ALLERGIES Do you have any allergies? Please include all medication allergies or food allergies. Have you ever had any life threatening allergic reactions?

Allergic to:	Reaction:	Severity:		
		mild	moderate	Life threatening
		mild	moderate	Life threatening
		mild	moderate	Life threatening
		mild	moderate	Life threatening

If you have a life threatening allergy, do you currently have an epipen or other intervention?

YES/ NO please explain:_____

PRIOR HOSPITAL ADMISSIONS Have you ever been hospitalized? When and why?
If needed, you can provide more details on the next page

Date of Admission:	Medical	Surgial	Intervention/ Reason for admission:
	Medical	Surgial	
	Medical	Surgial	
	Medical	Surgial	
	Medical	Surgial	
	Medical	Surgial	
	Medical	Surgial	

Do you now, or have you in the past had history of, any medical problems related to the body systems below? Please circle one.

If there is a problem NOW or IN THE PAST please explain in detail below.

Head	Now	In the past	Never
Eyes	Now	In the past	Never
Ears/Nose/Throat	Now	In the past	Never
Respiratory/Lungs	Now	In the past	Never
Chest Pain	Now	In the past	Never
Heart or blood vessels	Now	In the past	Never
Digestive tract	Now	In the past	Never
Liver (hepatitis, etc)	Now	In the past	Never
Genitourinary tract	Now	In the past	Never
Bones	Now	In the past	Never
Muscles	Now	In the past	Never
Hormone system	Now	In the past	Never

NEUROLOGICAL PROBLEMS:

If there is a problem NOW or IN THE PAST please explain in detail below.

Hearing	Now	In the past	Never
Vision	Now	In the past	Never
Head Trauma	Now	In the past	Never
Severe headaches	Now	In the past	Never
Seizures	Now	In the past	Never
Seizures only with high fevers	Now	In the past	Never
Encephalitis	Now	In the past	Never
Meningitis	Now	In the past	Never
Loss of consciousness or blackouts	Now	In the past	Never

Fainting	Now	In the past	Never
Trance-like episodes	Now	In the past	Never
Hormone system	Now	In the past	Never
Chronic dizziness	Now	In the past	Never
Double vision	Now	In the past	Never
Tremor	Now	In the past	Never
Unexplained poor coordination	Now	In the past	Never
Trouble walking	Now	In the past	Never
Memory problems	Now	In the past	Never

Please describe your current **sleep habits**:

	Bedtime:	
	Wake-up time:	

Please describe your current **appetite habits**:

	Picky eater	Grazer
	No problems	3 meals + snacks

Do you *currently or* have you *ever* had any serious medical illnesses? YES / NO

If Yes; Please describe all illnesses and their treatments:

Do you *currently or* have you *ever had* any serious injuries? YES / NO

If Yes; Please include *all* head injuries, concussions, losses of consciousness. Describe all injuries and their treatments. Did any require hospitalization?

Have you ever had surgery? YES / NO

If Yes; Please describe the surgery. Include the date and outcome:

MARRIAGE/DATING HISTORY

Currently married?	YES / NO	If Yes; specify:	Wife	Husband
Currently dating?	YES / NO	If Yes; specify:	Girlfriend	Boyfriend
Current Sexual activity:	YES / NO	If Yes, number of partners:		
Use of protection:	YES / NO	If Yes; explain:		
Recent Breakup:	YES / NO	If Yes; explain:		
Other Dating information:				

SUBSTANCE USE HISTORY

Do you currently or have you ever used any chemical substances resulting in medical or legal issues related to substance use? YES / NO

If Yes; Please explain:

EXPOSURE TO TOXIC OR DANGEROUS CHEMICALS OR MATERIALS: YES / NO

If Yes; Circle substance and please explain below including date/age of exposure:

Insulation	Asbestos	Fumes
Lead	Mercury	Plastics
Metals	Solvents	Dyes
Chemicals	Other Materials	

Have you traveled to a foreign country in the last 10 years? Yes/No

Where?_____ Date(s)of travel?_____

Were your immunizations up to date? YES/ NO

Are your immunizations currently up to date? YES/ NO

IS THERE ANYTHING ELSE YOUR PROVIDER SHOULD KNOW ABOUT YOUR MEDICAL HISTORY?

FAMILY HISTORY

Please report general and mental illness, addiction, neurological disorder, breathing or cardiac illness, early death, autoimmune disorders. Please indicate depression, bipolar disorder, schizophrenia, anxiety, eating disorder, autism, personality disorder, ADHD, Learning disorders specifically.

Father	
Mother	
Brother	
Sister	
Paternal Grandparents	
Maternal Grandparents	
Aunts/Uncles/Cousins	
Other	

Does any family member have any other medical illness or disorder, including hereditary disorders, your provider should know about? YES / NO

If Yes; Please explain:

Has any family member ever taken any psychiatric or mental health medication? YES / NO

If Yes; Please explain who it was and the medication purpose, effect, and/or result:

Has any family member ever had a psychiatric hospitalization, ECT (electroconvulsive therapy) or "shock treatment", suicide attempts? YES / NO If Yes; Please explain:

Has any family member ever been arrested or incarcerated? YES / NO If Yes; Please explain:

WOMENS HEALTH HISTORY

Number of Pregnancies		
How many prior live births? _____ How many prior miscarriages? _____		
Number of Deliveries	Cesarean:	Vaginal:
Any prior terminated Pregnancies?	YES	NO
If "YES" How many prior terminated pregnancies? _____		

Age of first menstrual period:		Number of days in cycle:		
Date of last period:		Cycles are:	Regular	Irregular
Any difficulties related to menstrual periods:	YES / NO	If Yes; explain:		
On Birth Control:	YES / NO	If Yes; explain:		

Have you ever had any difficulties or complications during pregnancy ? YES / NO If Yes; Please explain:

Any Serious Infection like Measles/German measles, Toxoplasmosis, Syphillis, Herpes, Flu or other virus? YES / NO If Yes; Please explain:

Was any pregnancy considered "high risk" Maternal age over 40 years or under 20 years, or advanced paternal age? YES / NO If Yes; Please explain:

Was any pregnancy shorter than 38 weeks or longer than 42 weeks? YES / NO If Yes; Please explain:

During pregnancy, did you engage in any of the following?

Smoking tobacco? YES/ NO If "yes", how much and during which trimester?

Drinking alcohol? YES / NO If "yes", how much and during which trimester?

Any drug use (i.e. marijuana, cocaine, ecstasy, etc.)? YES/ NO

If "yes", which drugs and during which trimester?

FAMILY SOCIAL HISTORY

Have there been any recent stresses in the family? YES / NO If Yes; Please explain:

Has anyone recently left the family or died? YES / NO If Yes; Please explain:

Has anyone recently joined the family? YES / NO If Yes; Please explain:

Have there been any recent employment changes or job losses? YES / NO If Yes; Please explain:

Have there been any recent financial changes (good or bad)? YES / NO If Yes; Please explain:

How many times has your family moved throughout your lifetime? _____ / N/A

Please explain your moves and reasons for moving:

IS THERE ANYTHING ELSE YOUR PROVIDER SHOULD KNOW ABOUT YOU AND YOUR FAMILY?