PS2C055

Smart Medicine
STONY BROOK
UNIVERSITY HOSPITAL
Expert Care

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._____

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

RELATIONSHIP	FIRST NAME	LAST NAME	AGE	OCCUPATION/ GRADE

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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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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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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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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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