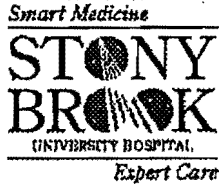


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**ADULT OUTPATIENT PSYCHIATRY
INTAKE QUESTIONNAIRE**

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 _____

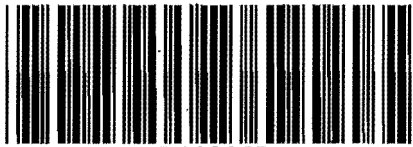
() Inpatient Medical () Inpatient Psychiatric () Emergency Room (Please specify)

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:

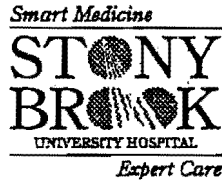
Please assess how current symptoms have affected the level of impairment in the following categories and indicate anticipated impairment at discharge.

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 _____

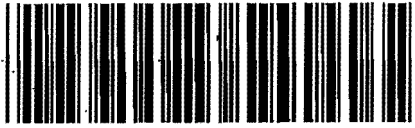
Number of jobs in the last 5 years _____

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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Smart Medicine

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: _____

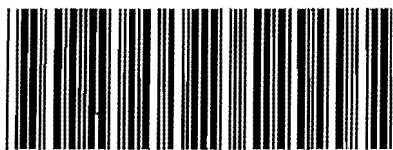
Hospital: _____

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)

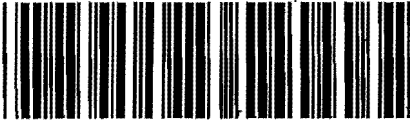
| NAME | AGE | HEALTH | MEDICAL & PSYCHIATRIC CONDITIONS | OCCUPATION/ SCHOOL GRADE | IF DECEASED AGE/CAUSE OF DEATH |
|------------|-----|--------|----------------------------------|--------------------------|--------------------------------|
| Father | | | | | |
| Mother | | | | | |
| Sibling 1 | | | | | |
| 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

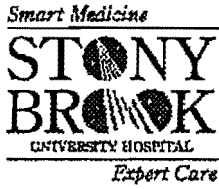
HAVE YOU EVER BEEN IN DETOX OR REHABILITATION PROGRAM? () YES () NO
IF YES PLEASE LIST:

| 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 |
|-------|-----------|-----------------|------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |