I N T A K E questionnaire — Eugene Dunaev, Psy.D.

- Please provide the following information for my records.
- Information you provide here is held to the same standards of confidentiality as our therapy.
- Please print out this form and bring it to your first session or allow yourself 30 minutes prior to your appointment to complete the form in the office. You can also scan and email the completed questionnaire to info@njpsych.net
- If any given question does not apply to you, please, put down "n/a" or "none"
- If are uncomfortable with any of the questions, you do not have to answer them

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Name: **Nickname:** **Birth Date**:

Address (with zip code):

Preferred Phone/Ok to leave a message? **E-mail:**

Name of your Insurance (from the insurance card): **Insurance ID #**:

Are you the primary subscriber for this insurance plan?

If not, what is the first/last name of the primary subscriber, their address and their phone number?

Your Gender: **Your Marital Status:** **# of Children (if any):**

Were you referred to this practice? By whom?

Presenting Problem(s): What brings you into treatment/counseling?

Why now?

When did these issues begin?

Are you currently in treatment with another mental health provider?

Are you currently on any psychotropic medication (e.g. antidepressants, etc.)?

If so, what are you currently taking? (please, list medication name and dose)?

Who is prescribing these medications for you?

Would like for me to confidentially touch base/contact your prescribing provider (for "coordination of treatment" and/or as an update)?

If you are not currently on psychotropic medication but you have been, what were you on and who prescribed this for you?

Have you had psychotherapy/counseling before? Who with?

HEALTH/SOCIAL/LEGAL HISTORY

1. How is your physical health? Any chronic physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.)?

2. Any sleep problems? If so, please, describe:

3. Do you have a regular wellness/exercise routine? If so, please, describe:

4. Any problems with appetite or eating? If so, please, describe:

5. Do you regularly use alcohol? Other substances? If so, please, describe (what, how often, how much):

6a. Have you ever been arrested/convicted/any D.U.I.s? If so, please, describe:

6b. Are you legally mandated/required to attend treatment/counseling?

7a. Do you ever thinking about killing yourself? Have you ever attempted to kill yourself? Please, describe:

7b. Are you suicidal now?

8. Are you having any relational problems? If so, please, describe:

9. What stresses you out at present/currently? Please, describe:

10a. Do you have any history of trauma? (Have you been sexually molested? Physically or emotionally abused?

10b. Any other kind of trauma – exposure to violence, life-threatening health diagnoses/problems?

Have you experienced the following symptoms	Ever?	Recently?
Extreme depressed mood	yes/no	yes/no
Wild Mood Swings	yes/no	yes/no
Rapid Speech	yes/no	yes/no

Extreme Anxiety	yes/no	yes/no
Panic Attacks	yes/no	yes/no
Phobias/Fears	yes/no	yes/no
Sleep Disturbances	yes/no	yes/no
Hallucinations	yes/no	yes/no
Unexplained losses of time	yes/no	yes/no
Unexplained memory lapses	yes/no	yes/no
Alcohol/Substance Abuse	yes/no	yes/no
Frequent Body Complaints	yes/no	yes/no
Eating Disorder	yes/no	yes/no
Body Image Problems	yes/no	yes/no
Repetitive Thoughts (e.g., Obsessions)	yes/no	yes/no
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)	yes/no	yes/no
Homicidal Thoughts	yes/no	yes/no
Suicidal Thoughts	yes/no	yes/no

HOSPITALIZATION HISTORY:

Have you ever been psychiatrically hospitalized? If so, voluntarily? Involuntarily? When/where? Please, describe:

PROFESSIONAL/OCCUPATIONAL HISTORY:

What is your education level?

What do you do for living?

Are you currently employed?

Are you currently in school? (If so, part-time? Full-time?) (please, circle)

FAMILY MENTAL HEALTH HISTORY:

Has any member of your immediate family received any psychiatric/psychological treatment? If so, please, describe (for what problem, what type of treatment)?

OTHER INFORMATION:

Do you like yourself? What do you like about yourself?

How do you cope?

What are your treatment goals?

What do you read? What do you watch on TV?

Do you have a meditation practice?

What, if any, is your religious/spiritual background?