

TOMMY J. MORGAN, M.D.
ADULT PSYCHIATRY
INTAKE QUESTIONNAIRE

This questionnaire is meant to collect important background information used in an intake interview with an adult. Please complete this form as accurately and thoroughly as possible.

Patient Information:

Patient's Full Name: _____
Age: _____ Gender: M F Date of Birth: _____ Social Security Number: _____
Preferred Mailing Address: _____
Patient's Contact Numbers: H _____ W _____ C _____
Patient's Title and/or Occupation: _____

Immediate Family or Friends if involved with your care:

Spouse's Name: _____
Spouse's Contact Numbers: H _____ W _____ C _____
Spouse's Title and/or Occupation: _____

Other Invidividual: _____
Relation to Patient: _____
Contact Numbers for Indiv: H _____ W _____ C _____
Parent's Title and/or Occupation: _____

Other Invidividual: _____
Relation to Patient: _____
Contact Numbers for Indiv: H _____ W _____ C _____
Parent's Title and/or Occupation: _____

Other Invidividual: _____
Relation to Patient: _____
Contact Numbers for Indiv: H _____ W _____ C _____
Parent's Title and/or Occupation: _____

Other Invidividual: _____
Relation to Patient: _____
Contact Numbers for Indiv: H _____ W _____ C _____
Parent's Title and/or Occupation: _____

Emergency Contact:

In an emergency, may we contact anyone besides a parent? Y N Contact's Relation: _____
Emer. Contact's Name: _____
Emer. Contact's Numbers: H _____ W _____ C _____

Referral Information:

Did anyone refer you to us? Y N If so, who? _____
Who is your primary care provider? _____
Please describe the reasons you are seeking an evaluation. _____

Review of Symptoms:

Please indicate any of the following symptoms that have been obvious and problematic.

Behaviors:

- Acting strangely.
- Attempting weight loss.
- Seeking attention.
- Arguing with others.
- Dreading work.
- Rejecting affection.
- Not listening to others.
- Not offering affection.
- Not staying on task.
- Difficulty waiting turn.
- Checking (as a ritual).
- Counting (as a ritual).
- Exercising excessively.
- Fidgeting a lot.
- Hoarding objects.
- Initiating fights.
- Insisting upon rituals.
- Interrupting others.
- Lacking follow through.
- Losing things.
- Showing inflexibility.
- Being perfectionistic.
- Startling easily.
- Taking risks.
- Talking excessively.
- Talking too fast.
- Washing hands repeatedly

Fears:

- Fearing abandonment.
- Fearing crowds.
- Fearing dying.
- Fearing embarrassment.
- Fearing gaining weight.
- Fearing losing loved ones.

Feelings:

- Feeling agitated.
- Feeling angry.
- Feeling anxious.
- Feeling cocky.
- Feeling depressed.
- Feeling indecisive.
- Feeling invincible.
- Feeling helpless.
- Feeling hopeless.
- Feeling lack of self-worth.
- Feeling moody.
- Feeling unstable.

Interpersonal:

- Having poor social skills.
- Feeling easily influenced.
- Lacking friends.

Thoughts:

- Forgetting things.
- Having delusions
- Having erratic thoughts.
- Having intrusive thoughts.
- Having paranoia.
- Having rapid thoughts.
- Hearing voices not there.
- Lacking focus.
- Lacking motivation.
- Lacking organization.
- Obsessing over symmetry.
- Seeing things not there.
- Thinking of death.
- Worrying about health.

Physical Symptoms:

- Feeling chills.
- Feeling muscle tension.
- Feeling nauseated.
- Feeling restless.
- Feeling sleepy in daytime.
- Feeling too energetic.
- Feeling too tired.
- Gaining appetite.
- Gaining weight.
- Losing appetite.
- Losing weight.
- Needing little sleep.
- Sleeping too little.
- Sleeping too much.
- Sweating.
- Trembling.

Mental Health Medications Previously Tried:

Name of Medication	Dosage	Dates of Treatment	Effect(s) from Medication

(Please continue on page margin if list exceeds the table.)

Allergies to Medication(s):

Do you have any known allergies to any medications? Y N If yes, then please list all medications that have caused an allergic reaction and describe the reactions to each one: _____

Family Psychiatric History:

Please indicate if your biological relatives have experienced the following.

- Anxiety Completed Suicide ADHD Psychosis
- Bipolar Disorder Depression Substance Abuse

Please describe the severity and time course for any of these conditions and describe any other psychiatric conditions that run in the family. _____

Social History:

Please describe where you were born and raised and also indicate places that you have lived. Please include approximate time periods for each location. Please also describe who was raising this individual during various time periods. _____

Have you ever been married? Y N If so, please describe the number of marriages durations of each. _____

Do you have children? Y N If so, please list the ages and gender for each child and indicate with whom these children live. _____

Please describe the highest level of school you have completed as well as any specialized degree programs you have completed if applicable. _____

Are you currently in school? Y N If so, what school and what kind of program are you taking? _____

Please describe your work history to include previous employment as well as your current job.

Have you ever been sexually abused? Y N
Have you ever been physically abused? Y N
Have you ever been emotionally abused? Y N
Have you ever had basic needs neglected? Y N

Habits:

Have you used illicit substances? Y N If so, please list all substances tried, maximum daily use, and approximate time period each substance was used. Please also list any legal difficulties faced due to illicit substance use: _____

Have you used alcohol? Y N If so, please list the age at first drink, maximum daily use, and approximate time period for use. Please also list any legal difficulties caused by use of alcohol.

Have you used tobacco? Y N If so, please list the age of first use, maximum daily use, and time period for use: _____

I have filled out the preceding information as accurately as possible.

Signature of Patient

Printed Name of Patient

Date Signed