I N T A K E questionnaire — Gary L Bushweiler PhD

- 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 email the completed questionnaire to **drgarylb@gmail.com**
- 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

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

Address (with zip code):

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

Gender: **Marital Status:** **Number of Children:**

Who referred you to this practice?

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

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? Therapist name?

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?

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)?

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

OTHER INFORMATION:

_____ _____

Signature of Patient (or personal representative) Date

_____

Printed name of representative