

CLINICAL NEUROSCIENCE CENTER, PLLC

Dr Daniel M. Dye, MD

Also practicing independently at this location

Dr Anita Blair, PsyD; John Evans, ARNP;

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ADULT INTAKE QUESTIONNAIRE

In order for us to be able to fully evaluate you, please fill out the following questionnaire to the best of your ability. We realize there may be information that you do not remember or have access to. Please just do the best you can. Thank you!

PATIENT IDENTIFICATION:

Name: _____

1st Appt Date: _____

Birth Date: _____

Age: _____ Sex: _____

Religion: _____

Marital Status: _____

Race: _____

Children: _____

Address: _____

City: _____

State: _____

Zip: _____

Home Phone # _____

Work # _____

Cell: _____

Email address: _____

REFERRAL SOURCE:

Who referred you to our office? _____

Address: _____ Phone # _____

Do we have your permission to release information to the referring professional when it is appropriate? _____ Yes _____ No

PURPOSE OF THE CONSULTATION:

(Please give a brief summary of the main problems)

Client ID: _____ Name: _____ Date: _____

Clinician Signature: _____

WHY DID YOU SEEK THE EVALUATION AT THIS TIME?

PRIOR ATTEMPTS TO CORRECT PROBLEMS

PRIOR PSYCHIATRIC HISTORY

(Please include contact with other professionals, medications, types of treatment, etc.)

What do you want this clinic to do for you?

MEDICAL HISTORY:

Current medical problems/medications: _____

Past medical problems/medications: _____

Other doctors/clinics seen regularly: _____

Any history of head trauma: (describe): _____

Ever any seizures or seizure like activity? _____

Any periods of "spaciness" or confusion? _____

Prior hospitalizations (place, cause, date, outcome): _____

Allergies/drug intolerances (describe): _____

Present Height: _____ Weight: _____

CURRENT LIFE STRESSES (include anything that is currently stressful for you: examples include relationships, job, school, finances, children): _____

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Client ID: _____ Name: _____ Date: _____

Clinician Signature: _____

FAMILY HISTORY:

Family Structure (who do you currently live with, add other information as necessary):

Significant Developmental Events (include marriages, separation, divorces, deaths, traumatic events, losses, abused, etc): _____

Current Marital or Relational Situation/Satisfaction: _____

History of Past Marriages: _____

Natural Mothers History: age: _____ outside work _____

School: Highest grade completed: _____

Learning Problems: (Specify): _____

Behavior Problems: (Specify): _____

Marriages: _____

Medical Problems: _____

Childhood atmosphere: (family position, abuse, illnesses, etc) _____

Has mother ever sought psychiatric treatment? Yes _____ No _____

If yes, for what purpose? _____

Mother's alcohol/drug use history: _____

Client ID: _____ Name: _____ Date: _____

Clinician Signature: _____

Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify) _____

Natural Father's History: age: _____ outside work _____
School: Highest grade completed: _____
Learning Problems: (Specify): _____
Behavior Problems: (Specify): _____
Marriages: _____
Medical Problems: _____
Childhood atmosphere: (family position, abuse, illnesses, etc) _____

Has father ever sought psychiatric treatment? Yes _____ No _____
If yes, for what purpose? _____

Father's alcohol/drug use history: _____

Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify) _____

Siblings (names, ages, problems, strengths, relationship to patient):

Children (names, ages, problems, strengths)

Client ID: _____ Name: _____ Date: _____
Clinician Signature: _____

EDUCATIONAL HISTORY

Last grade completed: _____

Last school attended: _____

Average grades received: _____

Any academic problems? _____

Learning strengths: _____

What would your teachers have said about you? _____

Employment History: (summarize jobs you've had, list most favorite and least favorite:

Any work-related problems? _____

What would your employers or supervisors have said about you? _____

Military History: _____

Every Any Legal Problems? _____

Alcohol and Drug History: (Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel: what benefit you got from them). These include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP.

Client ID: _____ Name: _____ Date: _____

Clinician Signature: _____

Ever experience withdrawal symptoms from alcohol or drugs? _____

Has anyone told you they thought you had a problem with drugs or alcohol? _____

Have you ever felt guilty about your drug or alcohol use? _____

Have you ever felt annoyed when someone talked to you about your drug or alcohol use?

Have you ever used drugs or alcohol first thing in the morning? _____

Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew)

Cultural/Ethnic Background _____

Describe your relationships with friends _____

Describe yourself _____

What are your goals in seeking this consultation? What do you hope to gain?

