Dr. Lisa Goldman
Clinical Psychologist

Intake Questionnaire

Name: _____
Please briefly describe your reasons for seeking help at this time:
_____
_____
_____
_____
_____
_____
_____
_____

Have you previously participated in therapy/counseling? Yes No
Who was your previous therapist(s)?
_____
Dates seen:
_____
Please list any diagnoses previously received:
_____
Have you previously seen a psychiatrist for medication?
_____
Previously prescribed psychiatric medications:
_____

Current psychiatric medications & dosages:
_____
_____
Have you ever been hospitalized for psychiatric reasons?
_____
When: _____ Where: _____
Do you have a history of suicidal thoughts _____suicide attempts _____?
Please elaborate:
_____
_____
_____
_____
_____

_____

Does a family member have mental illness or a substance abuse problem? Please explain:

_____
_____
_____

Who currently resides in your home? Please list names, ages & relationship to you:

_____
_____
_____

Your highest Level of education:

_____

Current Profession:

_____

Current Employment:

_____

Please list any ongoing medical issues or physical problems:

_____

Please list non-psychiatric medications you are currently taking (*please note name of medications, dosages & condition being treated)*:

_____
_____

List any allergies/serious accidents or illnesses/ hospitalizations/surgeries & year:

_____
_____

Do you smoke? _____ If yes, how much? _____

How much alcohol do you drink each day/week?

_____

Please check the symptoms or issues that apply to you (you can use more than one check if the symptom is severe):

_____ Depression (sadness)
_____ Sleep Difficulties / insomnia
_____ Problems regulating food intake
_____ Few Friends / Loneliness
_____ Sexual Problems
_____ Procrastination
_____ Panic Attacks
_____ Racing thoughts
_____ Recurrent, unwanted thoughts
_____ Rapidly changing moods
_____ People wanting to harm you
_____ Hearing things others don't hear
_____ Seeing things others don't see
_____ Cuts/burns or harms self
_____ History of Emotional/Physical/Sexual Abuse
_____ Current Suicidal thoughts/ attempts
_____ Thoughts of hurting others
_____ Dissatisfaction with appearance
_____ Easily irritated
_____ Victim of a violent crime or domestic abuse

_____ Anger, temper
_____ Weight loss
_____ Anxiety
_____ Difficulty concentrating
_____ Low Self-esteem
_____ Work stress
_____ Specific fears / phobias
_____ Unusual behavior
_____ Disorganization
_____ Few interests
_____ Loss/Grief
_____ Easily distracted
_____ Drug or alcohol abuse
_____ Legal problems

_____ Trouble being assertive
_____ Chronic physical pain
_____ Isolative, prefers to be alone