Lisa Sanchez, PhD, LLC
Clinical Psychologist
7910 Woodmont Ave, Suite 745
Bethesda, MD 20814
Phone: 301-742-6862

ADULT INTAKE QUESTIONNAIRE

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information

Personal Information

Name: ____________________________________ Date of Birth: ______________

Address: ____

Home Phone: __________________ May we leave a message (circle)? Yes No

Other Phone: __________________ May we leave a message (circle)? Yes No

**Please put a star by your preferred number*

Email: ____

Gender: _________________

Marital Status (circle):

Never Married Domestic Partnership Married

Separated Divorced Widowed

Children (circle) Yes No
If yes, how many and list their ages: ____

Who lives in the home? ____

Referred by (if applicable): ____

Emergency Contact

Name: ___________________________ Phone Number: ______________________

Relationship to you: ____

General Health Information

How would you rate your current physical health (circle one)?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

____

____

Mental Health Information

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.; circle)? Yes No
If yes, name of previous therapist/practitioner: _____________________________________

Are you currently taking any prescription medication (circle)? Yes No
If Yes, please list:

____

____

Have you ever been prescribed psychiatric medication (circle)? Yes No
If Yes, please list:

____

____

Please indicate (check) if you have **ever** experienced any of the following
☐Serious accident, fire or explosion
☐Natural disaster (tornado, flood, hurricane, major earthquake)
☐Non-sexual assault by someone you know (physically attacked/injured)
☐Non-sexual assault by a stranger
☐Sexual assault by a family member or someone you know
☐Sexual assault by a stranger
☐Military combat or a warzone
☐Sexual contact before you were age 18 with someone who was 5 or more years older than you
☐Imprisonment
☐Torture
☐Life-threatening illness
☐Other traumatic event (please list): _________________________________

Symptoms
Please check any symptoms or experiences that you have had in **the last month**

☐Difficulty falling or staying asleep	☐Tired/Lethargic
Average hours of sleep per night: _____	☐Spending increased time alone
☐Persistent loss of interest in previously enjoyed activities	☐Feeling Numb
☐Withdrawing from other people	☐Worthlessness
☐Depressed mood/Sadness	☐Helplessness
☐Rapid mood change	☐Hopelessness
☐Sadness	☐Increased/Decreased Energy
☐Changes in eating/appetite	☐Anxiety
☐Thoughts about harming or killing someone else	☐Irritability
☐Thoughts about harming or killing yourself	☐Panic attacks
☐Difficulty leaving your home	☐Outbursts of anger
☐Frequent feelings of guilt	☐Hair Pulling

☐Avoiding people/places/activities
☐Fear of certain objects of situations (i.e. flying, heights, bugs)
Describe: ____

☐Difficulty catching your breath	☐Increased muscle tension
☐Unusual sweating	☐Easily startled, feeling "jumpy"
☐Tremor	☐Dizziness
☐Physical sensations others don't have	☐Frequent Worry
☐Racing thoughts	☐Intrusive memories
☐Large gaps in memory	☐Flashbacks
☐Nightmares	☐Difficulty concentrating or thinking

☐Repetitive behaviors or mental acts (i.e. counting, checking doors, washing hands)
☐Persistent, repetitive, intrusive thoughts, impulses, or images

☐Use of substances to control weight	☐Binge eating
☐Voluntary vomiting	☐Binge eating

☐Feeling as if you were outside yourself, detached, observing what you are doing
☐Feeling puzzled as to what is real and unreal
☐Unusual visual experiences such as flashes of light, shadow
☐Hear voices when no one else is present
☐Feeling that your thoughts are controlled or placed in your mind

☐Difficulty meeting role expectations	☐Difficulty problem solving
☐Dependency on others	☐Concerns about your sexuality
☐Inappropriate expression of anger	☐Self-harm
☐Ineffective communication	☐Sense of lack of control
☐Decreased ability to handle stress	☐Abusive relationship
☐Difficulty or inability to say "no" to others	☐Difficulty expressing emotions

☐Interpersonal stress
☐Other symptoms, please describe:
____
____

Family History

Please place a check mark in the appropriate box if these are or have been present in your relatives

	Children	Brothers	Sisters	Father	Mother	Aunt/Uncle	Grandparents
Anxiety Problems							
Depression							
Hyperactivity/ ADHD							
Counseling							
Psychiatric Medication							
Psychiatric Hospitalization							
Suicide Attempt							
Death by Suicide							
Substance Use Problem							
Aggressive Behavior							