Nebraska Mental Health Centers

Intake Questionnaire

Family/Self Psycho-social History

Have you and/or anyone in your birth family experienced or been diagnosed with the following? Check all that apply.

Self	Family	
☐	☐	Mental Retardation
☐	☐	Speech or Communication Disorder
☐	☐	Attention-Deficit/Hyperactivity Disorder
☐	☐	Learning Problems/Disabilities
☐	☐	Pervasive Developmental Disorder
☐	☐	Autism Spectrum Disorder
☐	☐	Sleep Disorders
☐	☐	Eating Disorders
☐	☐	Anxiety Disorders (Panic, Phobias, Social Anxiety)
☐	☐	Post-Traumatic Stress
☐	☐	Obsessive-Compulsive Disorder
☐	☐	Depression
☐	☐	Manic-Depression/Bipolar Disorder
☐	☐	Sexual Disorders
☐	☐	Personality Disorders
☐	☐	Schizophrenia or other Psychosis

Self	Family	
☐	☐	Seizures or other Neurological Disorder
☐	☐	Genetic Disorder (e.g. Down Syndrome)
☐	☐	Dementia
☐	☐	Neglect
☐	☐	Emotional abuse
☐	☐	Physical abuse
☐	☐	Sexual abuse
☐	☐	Domestic violence
☐	☐	Legal problems
☐	☐	Financial problems
☐	☐	Alcohol/Substance Abuse
☐	☐	Serious illness
☐	☐	Accident or injury
☐	☐	Frequent/Multiple moves
☐	☐	Homelessness
☐	☐	Other: _____

Current Psychological Difficulties

Please check any that apply to you at this time

- ☐ Generalized Anxiety
- ☐ Specific fears/phobias
- ☐ Panic Attacks
- ☐ Obsessive thinking/repetitive behaviors
- ☐ Sadness/Depression
- ☐ Frequent crying
- ☐ Loss of energy
- ☐ Loss of pleasure in life
- ☐ Trouble waking up
- ☐ Fatigue/tiredness during the day
- ☐ Nightmares/Night terrors
- ☐ Memory problems
- ☐ Paranoia
- ☐ Problems with attention/concentration
- ☐ Racing thoughts
- ☐ Problems making/keeping friends
- ☐ Problems controlling temper
- ☐ Relationship/Marriage problems
- ☐ Problems with intimacy
- ☐ Problems with job
- ☐ Alcohol/drug use/abuse
- ☐ Financial problems
- ☐ Legal situation
- ☐ Mood swings
- ☐ Hallucinations
- ☐ Frequent body complaints
- ☐ Body image issues
- ☐ Other: _____

Have you ever or are you currently contemplating suicide?
☐ No ☐ Yes (Currently) ☐ Yes (Past)

Has anyone close to you (family/friends) ever attempted/committed suicide?
☐ Yes ☐ No

Have you ever or are you currently contemplating harming another person?
☐ No ☐ Yes (Currently) ☐ Yes (Past)

Health and Social Information

How is your health at present? (Select one)
☐ Poor
☐ Unsatisfactory
☐ Good
☐ Very Good

Please list any persistent physical symptoms or health concerns (e.g., chronic pain, headaches, hypertension, diabetes, etc.)

_____

_____

How many times per week do you exercise?
☐ 1 or less
☐ 2
☐ 3
☐ 4 or more

Rate the overall level of stress in your life.
☐ Very Low
☐ Low
☐ None
☐ High
☐ Very High

List any sources of stress in your life: _____

_____

_____

Are you having any problems with your sleep habits?
☐ Yes
☐ No

If yes, check where applicable:
☐ Sleeping too little
☐ Sleeping too much
☐ Poor quality sleep
☐ Disturbing dreams
☐ Other: _____

Have you ever or are you currently engaging in self-harm?
☐ No
☐ Yes (Currently)
☐ Yes (Past)

Are you having any difficulty with appetite or eating habits?
☐ Yes
☐ No

If yes, check where applicable:
☐ Eating less
☐ Eating more
☐ Binging
☐ Restricting

Have you experienced significant weight change in the last 2 months?
☐ Yes (gain)
☐ Yes (loss)
☐ No

Are you currently in a relationship?
☐ Yes
☐ No
If yes, please list status: _____

Number of marriages: _____
Number of divorces: _____
If widowed, your age at death of spouse: _____

Do you have children?
☐ Yes
☐ No
If yes please list below:

Medical Information

Do you now have, or have you had in the past, any of the following?

Now	Past		Now	Past		Now	Past	
☐	☐	Concussion/Loss of Consciousness	☐	☐	Allergies	☐	☐	Seizures
☐	☐	Asthma	☐	☐	Epilepsy	☐	☐	Diabetes
☐	☐	Brain Injury	☐	☐	Cancer	☐	☐	Heart Disease
☐	☐	Digestive Disorders	☐	☐	Immune System Problems	☐	☐	Hearing Problems
☐	☐	Breathing Problems	☐	☐	Vision Problems	☐	☐	Tuberculosis
☐	☐	High Blood Pressure	☐	☐	Urinary Disorders	☐	☐	Chronic Fatigue Syndrome
☐	☐	Arthritis	☐	☐	Multiple Sclerosis	☐	☐	Miscarriage (how many)
☐	☐	Thyroid Disorder	☐	☐	Pregnancy (how many)	☐	☐	Sleep Disorder
☐	☐	Fibromyalgia	☐	☐	Sexually Transmitted Disease	☐	☐	Other: _____
☐	☐	Abortion (how many)						
☐	☐	Serious Accident	☐	☐	Headaches			

List all medications you take, including prescription, psychotropics, over-the-counter, vitamins, drops, and topicals

List medications to which you are allergic

List any operations/medical procedures and the dates they took place

List any other hospitalizations and/or major injuries

Legal history

Have you ever been the victim of a crime?

☐ Yes
☐ No

Have you ever been convicted of a misdemeanor or felony?

☐ Yes
☐ No

Substances History

Please indicate substances currently used (over the past 6 months), how much at one time, how many times per day/week, age of first use, past use history, and length of time used.

Substance	Usage	Amount	Frequency	Age (of first use)
Caffeine	☐Current ☐Past			
Alcohol	☐Current ☐Past			
Tobacco	☐Current ☐Past			
Marijuana	☐Current ☐Past			
Ecstasy	☐Current ☐Past			
Cocaine/Crack	☐Current ☐Past			
Heroin	☐Current ☐Past			
Methamphetamines	☐Current ☐Past			
PCP/LSD/Mushrooms	☐Current ☐Past			
Painkillers	☐Current ☐Past			
Steroids	☐Current ☐Past			
Tranquilizers	☐Current ☐Past			
Sleeping pills	☐Current ☐Past			
Diet pills	☐Current ☐Past			

Have you ever believed your substance use was a problem for you?
☐ Yes
☐ No

Has anyone ever told you they believed your substance use was a problem?
☐ Yes
☐ No

Have you ever had withdrawal symptoms when trying to stop using any substances?
☐ Yes
☐ No

Have you ever had problems with work, relationships, health, the law, etc. due to your substance use?
☐ Yes
☐ No
If yes, please describe: _____

Have you ever participated in drug/alcohol treatment?
☐ Yes
☐ No

If yes please list type, length, dates, and age at the time you received these services: _____
_____

Do you currently or have you ever attended Alcoholics or Narcotics Anonymous?
☐ Yes
☐ No

If yes, please list length of time sober and number of meetings you attend per week: _____
_____