Reset Form

INTAKE QUESTIONNAIRE FOR PATIENTS/FAMILIES:

Please complete this form to the best of your ability to help us ensure accuracy and efficiency in the assessment process.

Patient name:_____ Date of Birth: _____

Person completing this form:_____ Relationship to patient: _____

Have you had previous behavioral health hospitalizations? □ Yes □ No If yes, when?_____

Name of Hospital_____ Reason for admission_____

Name of Hospital_____ Reason for admission_____

Do you have any pending legal problems? □ Yes □ No If yes, next court

date_____

Areas of Concern: Please check those that apply and give a brief explanation where applicable.

- □ Appetite change_____
- □ Sleep disturbance_____
- □ Tense or nervous feelings_____
- □ Marital or relationship stressors_____
- □ Problems at school/work_____
- □ Feelings of anger_____
- □ Excessive worrying_____
- □ Unwanted thoughts_____
- □ Difficulty concentrating_____
- □ Crying spells_____
- □ Loss of interest/enjoyment in activities _____
- □ Alcohol and/or drug use/abuse_____
- □ Easily annoyed or irritated_____
- □ Temper outbursts/destructive behavior_____
- □ Impulsiveness/acting without thinking_____
- □ History of physical or sexual abuse_____
- □ Feelings that others are out to get you_____
- □ Seeing or hearing things that others do not_____
- □ Feelings of wanting to harm others_____
- □ Feelings of wanting to harm self_____
- □ Suicidal thoughts □ Past □ Current_____
- □ Suicide attempts (if yes, when?)_____

What recent events/problems have brought about your request for help?_____

_____

Medical problems_____

Current medication and dosages _____

_____

_____

Do you take your medication as prescribed? □ No □ Yes

Patient/Family Signature _____ Date _____ Time _____

FACILITY USE ONLY:

Indicate Assessment Schedule:

- □ **Assessment scheduled**. Arrival Time: _____
- □ **Nursing review and assessment scheduled.**
  Staff reviewing with Nurse: _____ Nurse Name:_____
  Date of Review: _____ Time of Review: _____
  Arrival Time: _____
- □ **Physician review and assessment scheduled.**
  Staff reviewing with Physician: _____ Physician Name:_____
  Date of Review: _____ Time of Review: _____
  Arrival Time: _____