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Private Practice Intake Questionnaire (PPIQ) - CONFIDENTIAL

Rev. 12/13/18

Name_____ Date_____
Address_____
Phone: Work_____ Home_____ Cell_____ Email_____
Age_____ Date of Birth_____ Referred by_____

(please answer all questions briefly in 'bullet' style)

PRESENTING PROBLEM

Please state briefly what brings you here today (one or more issues).

Briefly describe the history of these problems (when did they start, how have the problems changed over time)

MENTAL HEALTH HISTORY

Have you ever been diagnosed with a mental illness? (please provide diagnoses and dates)

Do you receive, or have you previously received, mental health treatment? ____Yes ___No (If no, skip to Medical Information section) *(If you are unsure of exact dates, please give approximate dates).*
Please list current and previous psychotherapy:
Therapist_____ Dates_____-_____ Reason_____ Helpful?_____
Therapist_____ Dates_____-_____ Reason_____ Helpful?_____
Therapist_____ Dates_____-_____ Reason_____ Helpful?_____

Do you currently take psychiatric medications? ____Yes ___No
If yes, name of current prescribing MD: _____
MD's address and phone number: _____
Medication_____ Dose_____ Frequency_____ How long taken?_____
Medication_____ Dose_____ Frequency_____ How long taken?_____
Medication_____ Dose_____ Frequency_____ How long taken?_____
(If more, please list on back of sheet.)
Please list any other psychiatric medications you have taken previously and your response to them.

Have you ever been hospitalized for mental illness? (If yes, please list below)
Dates_____-_____ Hospital_____ Reason_____
Dates_____-_____ Hospital_____ Reason_____
Dates_____-_____ Hospital_____ Reason_____

Have you ever had psychological testing performed for learning or emotional difficulties? __Yes __No (If yes, say when testing was performed, reason for testing, and results if known)

MEDICAL INFORMATION

Do you have any present, or past, major medical condition? __Yes __No If yes, briefly describe.

Are you currently taking any medication for a non-psychiatric medical condition? __Yes __No
Medication_____ Dose_____ Frequency_____ How long taken?_____
Medication_____ Dose_____ Frequency_____ How long taken?_____

Any history of hospitalizations for medical illness? __Yes __No (If yes, please list below)
Dates_____-_____ Hospital_____ Reason_____
Dates_____-_____ Hospital_____ Reason_____

Any relevant family history of major medical illness?

Who is your primary care physician? Name_____ Phone _____
Address_____ Date of last visit_____

EDUCATION, SOCIAL ASSESSMENT & CURRENT LIVING SITUATION

What is your highest level of education obtained (dates, degrees, school attended, field of study)?

How have you traditionally performed academically? Any current or past school problems? (Include any history of learning disorder, behavioral problems, or special placement for learning problems.)

Are you currently working? __Yes __No If yes, list your current position and length of employment. If no, when is the last time you worked? What is the longest time you have worked?

List any entitlements you currently receive (SSI, Food Stamps, Medicaid, Section 8 housing, etc.).

How do you typically structure your time/day (work, sleep, socializing, group activities, TV, school, etc.)?

List some of your hobbies and interests.

Do you identify as religious? (Please state your religious preference and level of observance).

Briefly describe your current living situation (where you live, who else lives there, neighborhood).

Any past or current involvement with the legal system (lawsuits, arrests, time served)? If yes, explain.

RELATIONSHIPS AND SEXUALITY

Are you currently in an intimate relationship(s)? If yes, please briefly describe. Can you identify any relationship patterns or other issues important to address in treatment?

Do you have children? __Yes __No If yes, please state their age, gender, and the status of your current relationships with them.

How do you identify your sexual orientation?_____ Briefly mention any gender or sexual identity issues you may feel important to address in treatment.

Any problems with sexual functioning? __Yes __No If yes, briefly describe.

Briefly describe your current social network (friends, family, coworkers) and your level of satisfaction with the quantity and quality of people in your life.

FAMILY HISTORY

Please identify and briefly describe each person in the household of your family-of-origin (father, mother, stepparent, siblings, others).

Briefly describe your parents'/caretakers' occupations and education levels.

Briefly describe your parents' marital relationship and history.

Any history of mental illness in the family? __Yes __No If yes, briefly describe.

How are your current relationships with significant family members (e.g. mother, father, stepparent, etc.)?

ALCOHOL AND SUBSTANCE USE

How often do you currently drink and/or use recreational drugs? Describe how often, how much, and approximate start dates of use.

Substance_____ How often?_____ How much?_____ Start date?_____
Substance_____ How often?_____ How much?_____ Start date?_____
Substance_____ How often?_____ How much?_____ Start date?_____

Do you believe alcohol or substance use has a negative impact on your current functioning (mood states, health, relationships, work or school performance)?

Any past history of problem usage?

Substance_____ How often?_____ How much?_____ Start date?_____
Substance_____ How often?_____ How much?_____ Start date?_____
Substance_____ How often?_____ How much?_____ Start date?_____

Any history of treatment for problem use (12-step, AA, counseling, detox, 28-day, etc.)?

Treatment_____ Dates_____-_____ Reason_____ Helpful?_____
Treatment_____ Dates_____-_____ Reason_____ Helpful?_____
Treatment_____ Dates_____-_____ Reason_____ Helpful?_____

Any history of problem alcohol/drug use in your family?

TRAUMA HISTORY (please note BRIEFLY here, to be carefully discussed in the future)

History of premature losses?

History of traumatic illnesses, hospitalizations, injuries, or accidents?

History of verbal and/or emotional abuse?

History of neglect?

History of sexual trauma?

History of physical trauma or abuse (include experiences of harsh discipline)?

Have you ever been physically and/or sexually abusive with another person?

HIGH RISK BEHAVIORS

Do you currently have thoughts about suicide? __Yes __No If so, do you have a plan? Explain.

Is there a history of suicide in your family? __Yes __No

Do you currently have thoughts about harming others? __Yes __No If so, do you have a plan?

Do you engage in risky or self-injurious behaviors (cutting, dangerous sexual behaviors, other) __Yes __No

Do you ever lose control of your anger and act impulsively? __Yes __No

PSYCHIATRIC SCREENING QUESTIONS (write "N/A" if questions do not apply to you)

How would you describe your mood? (i.e. depression, mood swings, high sensitivity to the effect of others)

Have you ever had periods of time where you had too much energy?

How is your self esteem overall?

How often do you worry? What kind of things do you worry about?

Do you ever have episodes of sudden, intense worry or panic?

Do you ever have repetitive, irrational, worried thoughts that you feel you cannot control?

Do you ever feel compelled to engage in behaviors that give you relief from worry (i.e. checking, cleaning, handwashing, other rituals)?

Do you any have problems with sleep? (In general, number of hours of sleep you get per night: _____)

Do you ever feel suspicious that people are talking about you or want to hurt you? Do you have a difficult time trusting people? If yes, explain.

Do you ever hear things other people don't hear or see things other people don't see? If yes, explain.

Do you ever feel unreal or disconnected from your feelings, thoughts, or body? Do you ever enter into trance-like states?

Do you have any difficulties with memory?

Any issues of concern that have not been addressed?

How do you hope to benefit from treatment?

Thank you for completing this form. These topics will be addressed in more depth during our meeting.