the COLLECTIVE
INTEGRATED BEHAVIORAL HEALTH

Adult Patient Questionnaire

Please complete and return this questionnaire 48 hours prior to your scheduled intake.

Date:

Demographics:
Legal Name

Preferred Name

Gender Identity

Sexual Orientation

Pronoun(s)

Ethnicity

Religion

Relationship status [checkboxes]

- Single
- Partnered
- Married
- Separated
- Divorced
- Widowed
- Other: _____

Education/Job:
Employment status [checkboxes]

- Unemployed
- Part-time
- Full-time
- Contractor/free-lancer
- Full-time student
- Part-time student
- Other: _____

Employer/school:

Describe what brings you in for treatment today:

Which of the following are you experiencing (check all that apply)? [checkboxes]

- Depression
- Anxiety
- Panic attacks
- Inattention
- Hyperactivity/Impulsivity
- Nightmares/flashbacks

- Changes in sleep
- Repetitive behaviors
- Alcohol or substance use
- Intrusive thoughts
- Impulsive behaviors
- Difficulty navigating social situations
- Relationship conflicts
- Self-harm or suicidal thoughts
- Thoughts of hurting others
- Traumatic event(s)
- Other _____

Medical History:

Primary care clinician:

Last visit:

Medical diagnoses:

Current medical medications:

Medication	Dose	Frequency	Who prescribes?

Allergies:

Concussion History: ☐ Yes ☐ No; if yes please describe:

Seizure History: ☐ Yes ☐ No; if yes please describe:

If you are sexually active, please describe birth control use / safe-sex practices you utilize:

If applicable, pregnancy history/due date: (pregnancies, miscarriages, any complications):

Health History:

Please describe health in the following areas:
Nutrition, diet, and appetite (for example, changes in appetite or dietary restrictions): _____
Physical activity (for example, how much exercise do you get each week): _____
Sleep (for example, how many hours do you sleep each night): _____

Family Health History

1. Family Medical History: _____
2. Family Psychiatric History: _____
3. Family Substance Use History: _____

[ ] If family health history unknown, check here

Childhood/Family History:

Birth place:

Siblings:

Places lived:

Relationship with family members:

PSYCHIATRIC HISTORY:

Have you even been diagnosed with a mental health condition? Please describe.

Please list all current and past psychiatric medications you have been prescribed. Include approximate years.

Current psychiatric medications (include dose)	Previous psychiatric medications (include dose)

Psychiatric Treatment History: (Include dates, clinician name, outcome)

☐ Outpatient (office-based):

☐ Inpatient (emergency room / hospital-based):

☐ Residential:

☐ Partial Hospitalization:

☐ Intensive Outpatient:

☐ Other:

Please check substances you currently use/have used in the past: (describe how recent/often)

☐ Caffeine:
☐ Nicotine:
☐ Cannabis:
☐ Alcohol:
☐ Stimulants:
☐ Psychedelics:
☐ Benzodiazepines:
☐ Opioids:
☐ Other:

Have you ever experienced hearing sounds others can't hear or seeing things others can't see?

Do you have any legal history, such as charges, upcoming hearings, DUI, loss of license, current probation, incarceration history, or arrest history? Please describe if yes:

Concluding Questions

What would you describe as your strengths?

What are your goals for treatment? What do you want to be different, have more/less of?

Is there anything else you'd like us to know about you that has not been asked already?