MSU STUDENT HEALTH SERVICES
OLIN HEALTH CENTER
PSYCHIATRY CLINIC

Intake Questionnaire

Name: ____ *Student ID:* ___________

Gender: ____________________ *Date of birth:* ____________ *Age:* ________________

*Marital or Partner Status:*___________________ *School Status:* ______________________

Employment: ____ *Date:* _______________

This form will be given only to the clinician and any information you provide is confidential. If you are uncomfortable answering any or all of the questions of this form, you may leave them blank.

1. **PRESENTING COMPLAINT:** Why did you come in to the clinic today? How do you think we can be helpful?

2. **HISTORY OF PRESENTING COMPLAINT:** When did you start having a problem with this? How have you coped so far?

3. **CURRENT FUNCTIONING:**

   GPA/How are you doing in school?

   Sleep patterns (describe any changes, how many hours, start/stop, nightmares or other sleep disturbances)

   Eating habits (describe changes in appetite or weight loss/gain in last three months)

   Energy level (describe any changes)

   Learning difficulties (describe any problems with attention, concentration, memory, motivation, specific learning disabilities)

Name: ___________________________________ ID#: ______________________

Mood (describe any difficulties with sadness, tearfulness, irritability, hopelessness or helplessness, apathy, loss of pleasure)

Anxiety (describe any difficulties with worrying, feeling panicky, panic attacks)

Do you make yourself sick because you feel uncomfortably full?	Yes	No
Do you worry that you have lost control over how much you eat?	Yes	No
Have you recently lost more than 14 pounds in a 3-month period?	Yes	No
Do you believe yourself to be fat when others say you are too thin?	Yes	No
Would you say that food dominates your life?	Yes	No

Comments/Concerns

Work (describe any concerns with your job)

Relationships (describe any concerns with friendships, dating, roommates, partners)

Do you have friends or a support system in the East Lansing area?

Physical activity level (describe)

Stresses (describe)

Name: ______________________________________ **ID#:** ________________________

4. SUICIDAL/HOMICIDAL/ASSAULTIVE THOUGHTS OR BEHAVIORS:

Have you wished you were dead or wished you could go to sleep and not wake up?

Have you actually had thoughts of killing yourself?

Have you ever done anything, started to do anything, or prepared to do anything to end your life?

Do you do things to hurt yourself?

Have you ever wanted or do you currently want to hurt or kill someone?

5. TRAUMA (Specify recent or past):

Physical (abuse or accidents)

Emotional

Sexual

6. PSYCHOLOGICAL/PSYCHIATRIC TREATMENT (including medications):

Have you ever seen a counselor or a therapist?

Are you seeing a counselor or therapist now? If not, are you interested in finding one?

Have you ever seen a Psychiatrist?

When and for how long?

Who?

What diagnoses have been made?

Name: ____________________________________ ID#: ______________________

What medications have you tried for this?

Was treatment helpful or not helpful?

Were you hospitalized?

7. PERTINENT PERSONAL/FAMILY HISTORY (include history of mental illness, learning disabilities, hospitalizations, earlier diagnoses for self and family members)

Parent status (circle all that currently apply)
Married / Separated / Divorced / Remarried / Deceased / Other

Occupations: Parent 1:

Parent 2:

Sibling ages:

If you have children, what are their ages?

Family history (include extended family members) of mental illness, alcohol/drug abuse, hospitalizations, or suicide attempts

How have you gotten along with each parent?

Family member's health / medications

8. MEDICAL HISTORY

Allergic reactions to medications

Current medications (including over the counter and herbal products)

Current or past medical conditions or illnesses

Injuries or surgeries

Name: ___________________________________ ID#: ______________________

9. TOBACCO USE/HISTORY *[smoking and chewing]*

10. CAFFEINE INTAKE

11. ALCOHOL USE/AUDIT-C

<u>During the past month:</u>

How many times have you had more than 6 drinks in one day? _______

Questions	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many standard drinks containing alcohol did you have on a typical day when you were drinking in the past month?	0 -2	3 - 4	5 - 6	7 - 9	10+	
How often in the past month have you had 6 or more drinks in a day?	Never	Monthly or less	2 -4 times per month	2 - 3 times per week	4+ times per week	
Total Score						

How often during the past month has your drinking impacted your everyday life? For example, missing classes or submitting assignments late, doing something you would not do if you were sober, or drinking so much that you couldn't remember what you'd done the previous night/day

___ Never ___ Monthly or less ___ 2 - 4 times per month ___ 2 - 3 times per week ___ 4+ times per week

12. OTHER DRUG USE

Current use? Daily / Weekly / Monthly / Yearly

Past use?

Name: ___________________________________ ID#: ______________________

13. SEXUAL ACTIVITIES / PRACTICE OF SAFE SEX

Do you engage in sexual activity?

What is your sexual orientation?

Do you use a barrier method, i.e. condoms or dams every time to prevent sexually transmitted infections?

Do you know that free condoms, safer sex supplies, and free HIV testing are available at the Olin Health Education Services, room 371?

14. ARE THERE ISSUES OF DIVERSITY OR DIFFERENCE YOU WOULD LIKE TO DISCUSS? (Racial/ethnic issues, sexual orientation issues, religious/spiritual issues)

15. WHAT ARE YOUR GOALS FOR TREATMENT

This form was filled out by the patient and reviewed/appended by the treating physician.

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Physician signature **Date**