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Today's Date:

Revised:

Revised:

www.barringtonbhw.com
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INTAKE QUESTIONNAIRE

Your responses to the questions in this in this form are strictly confidential and will become part of your medical record.

Name <i>(Last, First, MI):</i>		<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> T	DOB:
Marital status:	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed How Long?		
Living with:	<input type="checkbox"/> Alone <input type="checkbox"/> w/Spouse <input type="checkbox"/> w/Partner <input type="checkbox"/> w/Roommate <input type="checkbox"/> w/Parents <input type="checkbox"/> Other:		
Primary or referring doctor:		Date of last physical exam:	
Employment:	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Under Employed <input type="checkbox"/> Disability <input type="checkbox"/> Other:		
Student:	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time Grade:		
Education:	<input type="checkbox"/> High School <input type="checkbox"/> GED <input type="checkbox"/> 2 Yr College <input type="checkbox"/> 4 Yr College <input type="checkbox"/> Graduate School <input type="checkbox"/> Technical School <input type="checkbox"/> Other		
Occupation:	Partner's Occupation:		

FAMILY CONSTELLATION

PLEASE PROVIDE THE FOLLOWING INFORMATION AND INCLUDE A ONE WORD "DESCRIPTION" OF EACH PERSON					
	AGE	WRITE A ONE WORD DESCRIPTION		AGE	WRITE A ONE WORD DESCRIPTION
Yourself			Partner	<input type="checkbox"/> M <input type="checkbox"/> F	
Father			Ex-Partner	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother			Ex-Partner	<input type="checkbox"/> M <input type="checkbox"/> F	
Grandmother <i>Maternal</i>			Grandmother <i>Paternal</i>		
Grandfather <i>Maternal</i>			Grandfather <i>Paternal</i>		
Sibling name			Children name		
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	

CURRENT SUPPORT SYSTEMS

<input type="checkbox"/> Close Friends <input type="checkbox"/> Group Friends <input type="checkbox"/> Family <input type="checkbox"/> Extended Family <input type="checkbox"/> Religious Group(s) <input type="checkbox"/> 12 Step Group(s)
<input type="checkbox"/> Other

CHALLENGES

Present psychological difficulties – please check any that apply to you at this time.

Generalized anxiety	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Specific fears / phobias (list):	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Panic attacks	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Social anxiety	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Obsessive thinking or compulsive behaviors (list):	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Sadness or Depression	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Emotionally overwhelmed	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Frequent crying	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Loss of energy	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Loss of pleasure in life	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Self-injurious / Self-harm behavior	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Thoughts of suicide	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Problems with eating	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Problems falling asleep	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Problems sleeping through the night (waking in the middle of the night or early morning)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Trouble waking up	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Fatigue / Tiredness during the day	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Nightmares	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Problems with attention or concentration	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Hearing strange voices	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Racing thoughts	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Memory lapses	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Problems making or keeping friends	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Problems controlling temper	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Physical Illness	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Eating disorder	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Relationship / Marriage problems	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Problems with intimacy	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Problems with job	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Problems with school	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Hopelessness	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
History of abuse (emotional, physical, sexual)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Alcohol / Drug use or abuse	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Financial Problems	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Legal situation	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Grief / Mourning	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Pain	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Hallucinations	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Guilt	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Worry	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Mood swings	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Codependency	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Repetitive thoughts	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Loneliness	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Perfectionism	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Rapid speech	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Impulsiveness	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

POSITIVE QUALITIES

Which of these qualities do you feel you 'have'?						
Creativity	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Sometimes
Curiosity	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Sometimes
Love of learning	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Sometimes
Wisdom / perspective	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Sometimes
Bravery	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Sometimes
Persistence	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Sometimes
Integrity	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Sometimes
Vitality	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Sometimes
Love	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Sometimes
Kindness	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Sometimes
Social Intelligence	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Sometimes
Fairness	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Sometimes
Leadership	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Sometimes
Forgiveness / Mercy	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Sometimes
Humility / Modesty	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Sometimes
Self-control	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Sometimes
Appreciation of beauty / excellence	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Sometimes
Gratitude	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Sometimes
Hope	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Sometimes
Humor / Playfulness	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Sometimes
Spirituality	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Sometimes

PREVIOUS TREATMENT

Are you currently seeing a therapist? (Name/contact phone #)

Have you ever seen a psychiatrist/psychotherapist before?: Yes No

Have you ever been treated for any of the following: (check all that apply)

<input type="checkbox"/>	Bipolar (Manic/Depressive) Disorder	<input type="checkbox"/>	Depression	<input type="checkbox"/>	ADHD
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	OCD	<input type="checkbox"/>	Schizophrenia
<input type="checkbox"/>	Panic Attacks	<input type="checkbox"/>	PTSD	<input type="checkbox"/>	Alcohol Problems (including AA)
<input type="checkbox"/>	Anorexia/Bulimia/Binge-eating	<input type="checkbox"/>	ECT treatment	<input type="checkbox"/>	Drug Problems

Please list in chronological order all prior psychiatric hospitalizations or treatment centers			
Approximate Date	Length of Stay	Name of Hospital	Reason for Admission

Have you ever attempted to harm/kill yourself? If so, please list the occurrences below: Never	
Approximate Date	How did you attempt (method)?

Please list *all* current medications below (include birth control pills, over the counter medication and herbal remedies – ie: decongestants, St. John's Wort, etc.).

Name of Medication	Dosage (mg)	How many times a day	On this for how long?	Side effects (if any)	Prescribing physician

FAMILY HISTORY

Has anyone in the birth family had any of the following psychological disorders? Check all that apply and list who (self, mother, father, sibling, child).		
Yes	Condition	Family Member
	Mental Retardation	
	Speech or Communication Disorder	
	Attention-Deficit /Hyperactivity / Impulsivity	
	Learning Problems / Disabilities	
	Autism Spectrum / Asperger's Disorder	
	Sleep Disorders	
	Generalized Anxiety (across many situations)	
	Social Anxiety	
	Obsessive-Compulsive Disorder	
	Phobias	
	Depression	
	Manic-Depression / Bipolar Disorder	
	Suicide attempts / Suicide	
	Schizophrenia or other psychosis	

Alcohol / Substance Abuse	
Seizures or other neurological disorder	
Genetic Disorder (e.g.; Down Syndrome, Fragile X)	
Other:	

Have you experienced in the past or currently have any of the following medical difficulties:

<input type="checkbox"/>	Chronic Illness	<input type="checkbox"/>	Chronic Pain	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Auto Immune Disease	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	Migraines
<input type="checkbox"/>	Infertility	<input type="checkbox"/>	Erectile Dysfunction	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Genetic Disorder

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)				
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?				
	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low	
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks/day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day	
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit			
Drugs	Do you currently use recreational or street drugs?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?				<input type="checkbox"/> Yes <input type="checkbox"/> No

DRUGS OF CHOICE

Please provide the following information as it applies to you for the following substances:

	Never Used	Age first used	Date last used	Age at peak use	History of abuse	Current use/frequency
Cocaine						
Amphetamines / Speed / Adderall						
Cannabis						
Diet Pills						
Hallucinogens (LSD, mushrooms, Mescaline)						
Ecstasy						
Diuretics						
Tranquilizers						
Khat / Bath Salts						
Pain Pills (Vicodin, Oxycontin, Dilaudid, Percocet, etc.)						
Laxatives						
Tobacco or "vape"						
Adderall						
PCP or Angel Dust						
Spice / K2						
IV Drug use						
Heroin						
GHB / Rohypnol						
Anabolic Steroids						
Caffeine (Coffee, Tea, Cola, Iced tea, Energy Drinks)						
Inhalants						
Benzodiazepines (Xanax, valium, Ativan, Restoril, Librium)						

Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> NO

CHILDHOOD

<input type="checkbox"/>	Happy Childhood	<input type="checkbox"/>	Neglected / Isolated	<input type="checkbox"/>	Physical Abuse
<input type="checkbox"/>	Sexual Abuse	<input type="checkbox"/>	Alcohol in family	<input type="checkbox"/>	Drugs in family
<input type="checkbox"/>	Mental health issues in family	<input type="checkbox"/>	Conflict & Fighting	<input type="checkbox"/>	Divorce
<input type="checkbox"/>	Remarriage	<input type="checkbox"/>	Step Siblings	<input type="checkbox"/>	Frequent Moves

As a child you were: (check all that apply)

<input type="checkbox"/>	Given direction	<input type="checkbox"/>	On your own	<input type="checkbox"/>	Silent
<input type="checkbox"/>	Anxious	<input type="checkbox"/>	Depressed	<input type="checkbox"/>	Talkative
<input type="checkbox"/>	Good Grades	<input type="checkbox"/>	Poor Grades	<input type="checkbox"/>	Sad
<input type="checkbox"/>	Popular	<input type="checkbox"/>	Few Friends	<input type="checkbox"/>	Angry
<input type="checkbox"/>	Spoiled	<input type="checkbox"/>	Neglected		

As a child did you experience: (check all that apply)

<input type="checkbox"/>	Verbal Abuse	<input type="checkbox"/>	Physical Abuse	<input type="checkbox"/>	Threats to self or others
<input type="checkbox"/>	Abandonment	<input type="checkbox"/>	Necessities withheld	<input type="checkbox"/>	Had to be the 'grownup'
<input type="checkbox"/>	Sudden death of a relative	<input type="checkbox"/>	Accidents to self or others	<input type="checkbox"/>	Illnesses of self or others
<input type="checkbox"/>	Witness violence	<input type="checkbox"/>	Inappropriately touched	<input type="checkbox"/>	Incest
<input type="checkbox"/>	Rape	<input type="checkbox"/>		<input type="checkbox"/>	

What is your mood right now:

<input type="checkbox"/>	Euphoric	<input type="checkbox"/>	Elated	<input type="checkbox"/>	Cheerful
<input type="checkbox"/>	Tranquil	<input type="checkbox"/>	Calm	<input type="checkbox"/>	Anxious
<input type="checkbox"/>	Panicky	<input type="checkbox"/>	Fearful	<input type="checkbox"/>	Worried
<input type="checkbox"/>	Enraged	<input type="checkbox"/>	Angry	<input type="checkbox"/>	Agitated
<input type="checkbox"/>	Apathetic	<input type="checkbox"/>	Depressed	<input type="checkbox"/>	Remorseful
<input type="checkbox"/>	Hopeless	<input type="checkbox"/>	Suicidal	<input type="checkbox"/>	Hopeful

WHY HERE – WHY NOW?

Describe your reason for coming today & why now?

Mood State	Relationship Issue	Employment
Substance Use	Medical Issue	Recent life event

Why here – why now?

Who else needs to be involved?

What are your goals?