DENISE GRETCHEN-DOORLY, PH.D.
DR. DOORLY

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INTAKE QUESTIONNAIRE

SECTION A: BACKGROUND INFORMATION

(A1) GENDER

☐ Female ☐ Male ☐ Transgender ☐ Other (identify) _____

(A2) ETHNICITY

☐ African American
☐ White/Caucasian
☐ Latino/Latino American/Hispanic
☐ Chinese/Chinese American
☐ Canadian
☐ Native American/Alaskan Native
☐ Japanese/Japanese American
☐ Polynesian/Micronesian
☐ Other _____
☐ Korean/Korean American
☐ Chicano/Mexican American/Puerto Rican
☐ European
☐ Middle Eastern
☐ East Indian/Pakistani
☐ Filipino/Pilipino
☐ Vietnamese/Vietnamese American
☐ Multiracial/Multiethnic
☐ Prefer Not to Answer

(A3) SEXUAL ORIENTATION:

☐ Bisexual ☐ Heterosexual ☐ Lesbian/Gay ☐ Queer ☐ Questioning
☐ Other (identify) _____

(A4) RELATIONSHIP STATUS:

☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
☐ Other (specify) _____

Do you have any children? ☐ Yes ☐ No

If you have children, please list their genders and ages (i.e. 2 year old daughter, 6 year old stepson, 9 year old foster son, etc.)

_____
_____

(A5) RESIDENCE:

How long have you resided at your current address? _____

Who lives with you? _____

Please check one: ☐ Rent ☐ Own ☐ Other (specify) _____

(A6) EMPLOYMENT:

Are you currently employed? ☐ Yes ☐ No

(A6) EMPLOYMENT (continued):

If you <u>are</u> currently employed, what type of work do you do? _____

How long have you worked there? _____

How many hours per week do you work? _____

How satisfied are you in your job? (check one)
☐ Very Satisfied ☐ Somewhat Satisfied ☐ Not Satisfied ☐ Extremely Unhappy

If you <u>are not</u> currently employed, what was your last paid job? _____

When did you leave your last job? _____

Why did you leave your last job?

_____

_____

(A7) EDUCATION

How far did you get in school?

☐ Some High School ☐ High School Diploma/GED ☐ Some College ☐ College Degree
☐ Some Graduate School ☐ Graduate Degree ☐ Other (specify)_____

Did you experience LEARNING PROBLEMS in elementary/grade school, high school or college?
☐ None ☐ A little ☐ Some ☐ Substantial ☐ A lot, constant struggle

If you are <u>currently attending</u> **college**, please specify your school/university _____ and your major(s) _____. What year are you in? (i.e. 1st, 2nd, etc.) _____

If you are <u>currently attending</u> **graduate school**, please specify your school/university_____, degree program(s) (i.e. MA, MS, MD, JD, PhD, PsyD, etc.) _____ and your field(s) of specialization _____. What year are you in? (i.e. 1st, 2nd, etc.) _____

If you <u>earned a **college degree**</u>, please specify type of degree (i.e. AS, BA, BS, BFA, etc.) _____, your school/university _____ , and your major(s)_____

If you <u>earned a **graduate degree**</u>, please specify type of degree(s) (i.e. MA, MS, MD, JD, PhD, PsyD, etc.) _____, your school/university _____ , and your field(s) of specialization _____

(A8) RELIGION

What is your religion?
□ Jewish □ Christian □ Catholic □ Protestant □ Presbyterian □ Episcopalian □ Buddhist
□ Muslim □ Hindu □ Atheist □ Agnostic □ Mormon □ Baptist □ Methodist
□ Other (specify)_____

Are you currently active in your religion? □ Yes □ No

SECTION B: PRESENTING CONCERN(S)

(B1) Briefly describe what brings you to psychotherapy at this time:

_____

_____

_____

(B2) Approximately how long has/have this/these concern(s) been bothering you?
□ Days □ Week □ Month □ Several Months □ Year □ Several Years □ Most of my life

(B3) Please CIRCLE ANY ITEMS THAT APPLY to what is concerning you **now**:

(1) Academic concerns
(2) Faculty/advisor concerns
(3) Adjustment to school
(4) Graduation preoccupations
(5) Procrastination
(6) ADHD/learning problems
(7) Re-entry concerns
(8) Career/job concerns
(9) Trouble making decisions or getting things done
(10) Harassment
(11) Discrimination
(12) Adjustment to new situations
(13) Stress or tension
(14) Concentration difficulties
(15) Anxiety, fear, nervousness
(16) Panic Attacks
(17) Obsessive thoughts
(18) Phobias
(19) Paranoia
(20) Compulsive behavior
(21) Impulse control
(22) Racing thoughts
(23) Episodes of manic behavior
(24) Addiction
(25) Hearing voices other can't hear
(26) Health/medical issues
(27) Identity/sense of self
(28) Cultural/multicultural concerns
(29) Self-esteem
(30) Spiritual or religious concerns
(31) Sexuality concerns
(32) Relationship concerns
(33) Family problems
(34) Anger management
(35) Physical abuse or assault
(36) Sexual abuse or sexual assault
(37) Emotional or psychological abuse
(38) Intimate relationship concerns
(39) Concern with other's well-being
(40) Interpersonal concerns
(41) Mood swings
(42) Feeling doomed or helpless
(43) Loneliness
(44) Depression, sadness
(45) Thinking about suicide
(46) Cutting or self injury
(47) Loss, grief, death
(48) Sleep difficulties
(49) Legal concerns
(50) Financial concerns
(51) Alcohol or drug concerns
(52) Seeing things that aren't there
(53) Other: _____

(B4) Which of the above concerns are <u>most important</u> to you: (e.g., "1", "12", "53") _____

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SECTION C: HEALTH HISTORY

(C1) When was your last physical exam? _____ Who performed the exam? _____

(C2) How is your physical health at present? □ Poor □ Unsatisfactory □ Satisfactory □ Good □ Excellent

(C3) Have you had any serious accidents, injuries, or illnesses?? □ Yes □ No If YES, please describe:

_____

_____

_____

(C4) Are you presently taking any medication prescribed by a licensed healthcare provider? □ Yes □ No

If YES, please list:

Medication Name	Daily Dose	Reason(s) for Taking	Name of Prescribing Professional

(C5) Are you taking any over-the-counter medications or supplements? (i.e. Prilosec OTC, Advil, Multivitamin, Echinacea, St. John's Wort, Aloe Vera, Omega Fish Oils, etc.) □ Yes □ No

Name of OTC Medication/Supplement	Daily Dose	Reason(s) for Taking

(C6) Please list any PERSISTENT PHYSICAL SYMPTOMS, health concerns, or diagnoses (e.g., chronic pain, headaches, hypertension, diabetes, etc.):

_____

_____

_____

_____

_____

(C7) Are you having any problem with your sleep habits?

☐ No problems ☐ Sleeping too much ☐ Sleeping too little ☐ Poor quality of sleep
☐ Disturbing dreams ☐ Other (please describe) _____

(C8) How many times per week do you exercise? ☐ 1 or less ☐ 2 to 4 ☐ 5 or more

What type(s) of exercise do you engage in (i.e. walking, jogging, crossfit, yoga, pilates, aerobics, dance, etc.)?

_____

How much time is spent on each exercise session? _____

(C9) Are you having difficulty with appetite or eating habits?

☐ No difficulty ☐ Eating less ☐ Eating more ☐ Bingeing ☐ Restricting
☐ Significant weight gain or loss ☐ Other (specify) _____

(C10) Do you have any problems or worries about sexual functioning? (check all that apply)

☐ No concerns ☐ Lack of desire ☐ Performance problem ☐ Sexual impulsiveness
☐ Difficulty maintaining arousal ☐ Worried about sexually transmitted disease
☐ Other (specify)_____

(C11) Besides family members, approximately how many people can you really count on right now for friendship and emotional support?

_____

(C12) Approximately how many significant intimate or romantic relationships (lasting 6 months or more) have you been involved in the last couple of years?

_____

(C13) Are you in a significant intimate relationship now? ☐ Yes ☐ No ☐ Not Sure

SECTION D: MENTAL HEALTH HISTORY

(D1) Have you received counseling or psychotherapy <u>in the PAST</u>? ☐ Yes ☐ No

If YES, what for? _____

With whom? _____ For how long? _____ Did it help? ☐ Yes ☐ No ☐ Not Sure

(D2) Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere?

□ Yes □ No

If YES, please write down your current mental health provider's name and phone number:

Provider's Name: _____

Provider's Phone Number: _____

(D3) Have you been prescribed psychiatric medication in the PAST? □ Yes □ No

If yes, please list medication name, when taken, and reason(s) prescribed (i.e. Prozac, 2002-2004, depression).

Name of medication	Date(s) of Use	Reason(s) Prescribed

(D4) Are you CURRENTLY taking prescribed psychiatric medication? □ Yes □ No

If you are CURRENTLY taking psychiatric medication, please list the medication name, the daily dose, and the prescribing psychiatrist/physician (i.e. Prozac, 20 mg, Dr. Jane Doe - Psychiatrist)

Name of medication	Daily Dose	Prescribing psychiatrist/physician

Is your psychiatric medication helpful? □ Yes □ No □ Not Sure

(D5) Have you been hospitalized for **psychiatric** reasons? ☐ Yes ☐ No

Please describe the nature of your psychiatric hospitalization(s):

Date of hospitalization	Hospital Name & Location	Reason(s) for Hospitalization (i.e. suicidal, threatened to harm others, addiction, unable to care for self, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Was hospitalization helpful? ☐ Yes ☐ No ☐ Not Sure

(D6) Have you ever had thoughts of harming yourself? ☐ Yes ☐ No

(D7) Have you purposely injured yourself without suicidal intent? (e.g., cutting, burning, etc.) ☐ Yes ☐ No
If YES, when did this occur? ☐ In the past but stopped ☐ In the past and currently going on
☐ Recently started

(D8) In the last few days, have you had suicidal thoughts? ☐ Yes ☐ No

If YES, please answer the following questions:

FREQUENCY: ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Always
DURATION: ☐ Seconds ☐ Minutes ☐ Hours ☐ Always
INTENSITY: ☐ Brief and fleeting ☐ Focused deliberation ☐ Intense rumination

(D9) Have you seriously considered attempting suicide in the past? ☐ Yes ☐ No

(D10) Have you ever made a suicide attempt? ☐ Yes ☐ No

(D11) Have you ever seriously considered harming another person? ☐ Yes ☐ No

(D12) Have you ever intentionally physically harmed someone? ☐ Yes ☐ No

(D13) Do you CURRENTLY have thoughts of harming another person? ☐ Yes ☐ No

SECTION E: SUBSTANCE USE

(E1) Do you regularly use alcohol? ☐ Yes ☐ No

(E2) In a typical month, how often do you have 4 OR MORE DRINKS in a 24-hour period?
☐ Never ☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily

(E3) Do you consider your alcohol consumption a problem? ☐ Yes ☐ No ☐ Not Sure ☐ N/A

(E4) Have you used any drug in the past 30 days that was not prescribed by a doctor? (e.g. marijuana, meth, cocaine, diet pills, ecstasy, Xanax, valium, Ritalin, Adderall, LSD, acid, mushrooms, heroin, codeine, etc.)
□ Yes □ No

If YES, please indicate which substances and when you used them:

Name of Substance	Date(s) Used	Name of Substance	Date(s) Used

(E5) How often do you use recreational drugs?
□ Never □ Rarely □ Monthly □ Weekly □ Daily or Almost Daily

(E6) Do you consider your drug use a problem? □ Yes □ No □ Not Sure □ N/A

(E7) Have you ever received treatment for alcohol or drug use? □ Yes □ No
If yes, was your drug and/or alcohol treatment program helpful? □ Yes □ No □ Not Sure

(E8) What is your typical DAILY CAFFEINE intake?
□ Never □ Infrequently □ 12-24 oz OR 1-2 cups/servings □ 25-60 oz OR 3-5 cups/servings
□ More than 60 oz OR 5+ cups/servings

(E9) What is your typical DAILY NICOTINE intake?
□ Never □ Infrequently □ Less than 5 cigarettes □ 5-20 cigarettes □ More than 20 cigarettes
□ Other (e.g., nicotine patch)

SECTION F: FAMILY & CULTURAL BACKGROUND

(F1) Please list the members of your current family, including ages and occupations (e.g., "Mother, 50, accountant")

Family Member	Age	Occupation (if known or applicable)

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(F2) Were you and both your parents born in the USA? ☐ Yes ☐ No (specify below)

If NO, please describe who was foreign-born, where, and what was the approximate age of immigration (e.g. Mother, Mexico, age 8):

Foreign Born Relative	Country of Birth	Age of Immigration
_____	_____	_____
_____	_____	_____
_____	_____	_____

(F3) In general, how happy or adjusted were you growing up?
☐ Not at all ☐ Unsatisfactory ☐ Average ☐ Substantially ☐ Completely

(F4) Do you speak a language other than English at home?
☐ No ☐ Very little ☐ Sometimes ☐ All the time | If YES, what language(s) do you speak? _____

(F5) How much do you identify with your ethnic heritage?
☐ Not at all ☐ A little ☐ Somewhat ☐ Moderately ☐ Strongly

(F6) How much is your immediate family a source of emotional support for you?
☐ Not at all ☐ A little ☐ Somewhat ☐ Moderately ☐ A lot

(F7) Have you personally experienced LEGAL PROBLEMS in the past? ☐ Yes ☐ No

If YES, please describe:

_____
_____
_____
_____
_____

(F8) Are you currently experiencing LEGAL PROBLEMS? ☐ Yes ☐ No

If YES, please describe:

_____
_____
_____
_____
_____

Thank you for taking the time to complete this questionnaire. I look forward to learning more about you during our first session.