

# OCPA Intake Questionnaire

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M F Date: \_\_\_\_\_

Insurance: \_\_\_\_\_ Referral Source: \_\_\_\_\_

## **Goals**

What is the main reason for which you seek treatment?: \_\_\_\_\_

What would you like to achieve through treatment? \_\_\_\_\_

## **Psychiatric History**

Have you previously been treated for psychiatric conditions? (please list): \_\_\_\_\_

Please list any current psychiatric medications, with dose (if known) : \_\_\_\_\_

Who is prescribing these medications? \_\_\_\_\_

Please list any past psychiatric medications (include how long you took them and the outcome): \_\_\_\_\_

Are you currently in therapy/counseling? If so, with whom and how often?: \_\_\_\_\_

Have you ever been hospitalized for a psychiatric reason, either in the ER or on an inpatient unit?: \_\_\_\_\_

## **Medical History**

Do you have a history of any medical conditions (include childhood problems)?: \_\_\_\_\_

Please list any current medications (non-psychiatric), with dose (if known): \_\_\_\_\_

Have you had any surgeries? \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_

When was your last physical exam/labs & what were the findings?: \_\_\_\_\_

Are you allergic to any medications?: \_\_\_\_\_

What is your approximate height/weight currently? \_\_\_\_\_ Avg wt? \_\_\_\_\_

**Family History**

Does anyone in your family have any mental health/psychiatric problems? Whom and what issues? \_\_\_\_\_

Does anyone in your family abuse drugs or alcohol? \_\_\_\_\_

Does anyone in your family have significant medical problems (e.g. heart disease, stroke, cancer, diabetes, kidney/liver problems, thyroid problems, autoimmune problems)? \_\_\_\_\_

**Social History**

Where are you living and with whom? \_\_\_\_\_

Marital/Partner Status: \_\_\_\_\_ Names/Ages of Children (if applicable): \_\_\_\_\_

Are you employed? What kind of work?: \_\_\_\_\_

Where did you grow up? \_\_\_\_\_ Highest grade/degree: \_\_\_\_\_

Where do your parents/siblings live? Relationship with them?: \_\_\_\_\_

Do you have a history of abuse towards you of any kind?: \_\_\_\_\_

Have you had any major changes or stresses in your life recently? \_\_\_\_\_

Who is your main support? \_\_\_\_\_

**Substance History**

Do you drink alcohol? If so, state your average use and type/quantity: \_\_\_\_\_

Do you smoke cigarettes or marijuana? If so, how often? \_\_\_\_\_

Do you currently use any other substances? (i.e. speed, ecstasy, cocaine etc)? \_\_\_\_\_

Have you used substances in the past?: \_\_\_\_\_

Have you ever been in any substance abuse treatment program/rehab of any kind? \_\_\_\_\_

Patient Signature

Date