MidValley Healthcare

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ADULT INTAKE QUESTIONNAIRE

Please DOWNLOAD and complete forms in Acrobat (not in the web browser), save, email to Admin@midvalleyhealthcare.com , RoxanneH@midvalleyhealthcare.com , and gillies.katie@midvalleyhealthcare.com.
Note: By printing your name on the signature line, you consent to treatment.

Please take enough time to complete this questionnaire thoroughly, but be **brief** with your responses when possible. Feel free to put 'NA' when 'not applicable', a question mark if 'not known,' or simply check-mark the space in response to yes/no questions; but **please DO respond to every item**—medical record accuracy and completeness make for a good foundation for successful treatment. Know that **we honor your confidentiality;** consequently, you can be sure that none of your medical record information, including that provided on this form, will be released without your full knowledge and/or expressed consent. Thank you.

NAME: _____ **DOB:**_____

Please **briefly** describe the reason you are here / your current problem(s):

- ☐ Hospital follow for Mental Health treatment
- ☐ Hospital follow for Chemical dep. Treatment
- ☐ Other:_____

Do you have large quantities of medication in your home? ___Y ___N
Do you have access to these medications? ___Y ___N
Are the medications kept in a locked container? ___Y ___N

Do you have weapons (including firearms) in your home? ___Y ___N
Do you have access to these weapons? ___Y ___N
Are the weapons kept in a locked container? ___Y ___N

PAST PSYCHIATRIC HISTORY:

How old were you when you first encountered mental health services and what compelled your referral or involvement at that time:_____
Have you undergone previous counseling? _____ When (how old were you)?_____
Reason?_____

Have you been **hospitalized for psychiatric** reasons? ___N ___Y : How many times:___
When(age, grade or date is fine) were you first **psychiatrically hospitalized** and **why**:_____
_____
When was the most **recent** hospitalization and why:_____
_____

Have you any past suicide attempts? _____No _____Yes, and how many times? _____
If yes, by what method:_____
If you have attempted suicide more than once, how old were you when first attempted:_____
Age at last attempt:_____

Please list any health providers you are currently being treated by:
Psychiatrist:_____
Counselor:_____
PCP:_____
Other:_____

If you would like MidValley Healthcare to send or receive records, please ask the front desk for a Release Of Information.

Please list **past psychiatric medications** you have taken**:** None?_____

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

*2321 E Gala Street, Ste 3 * Meridian, ID 83642 * Main Phn: (208) 888-5848 Fax: (208) 888-0884*
*Updated: 2/4/2020 303 N Allumbaugh St. Ste 335 * Boise, ID 83704*

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Please list your **current psychiatric medications** (name, dose, and directions): None?_____

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

FAMILY HISTORY:

Do any members of your immediate or extended family have psychiatric illness? If so, please list the diagnoses and circle if on your maternal (mother) or Paternal (father) side:

1._____ ○Maternal ◉Paternal 4._____ ◉Maternal ○Paternal

2._____ ◉Maternal ○Paternal 5._____ ◉Maternal ○Paternal

MEDICAL HISTORY:

Do you have any known medic ation allergies? ○ Y ○ N

If yes, please list the medication and the reaction:_____

_____

List any infectious diseases you may have (Hepatitis, TB, Pertussis, HIV, etc.):_____

_____

List any surgeries you've had:_____

List any chronic medical illness you know you have (i.e. asthma, arthritis, diabetes, high blood pressure, etc.):_____

_____

List any **non-psychiatric** medications you are currently taking for medical problems:

1) _____ 3) _____ 5) _____
2) _____ 4) _____ 6) _____

Name and phone number of prescribing provider:_____

If you would like MidValley Healthcare to share information with this provider, please complete a Release of Information.

PSYCHOSOCIAL HISTORY:

Born where (State)? _____ Raised by biological parents or other (explain):_____

If your parents separated/divorced, approximately how old were you?_____

Childhood: OK? _____ Not OK? _____ If not, briefly state why?_____

History of having been physically abused: ○ Y ○ N

If yes, briefly explain over what age period & by whom:_____

_____

History of having been sexually abused: ○ Y ○ N

If yes, briefly explain over what age period & by whom:_____

_____

DRUG/ALCOHOL HISTORY:

Drug or Alcohol Use? ○ N ○ Y Which Substances:_____

If so, beginning **approximately** when (at what age or grade in school)?_____

Have you ever been in substance abuse treatment? ○ N ○ Y

If yes, outpatient or inpatient and at what age?_____

LEGAL HISTORY: ○ Y ○ N

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Please describe any legal problems you have or have had:_____
_____

EDUCATIONAL HISTORY:

High School Graduate: ◯ Y ◯ N Last Grade Attended: _____
GED: ◯ Y ◯ N
Special Ed: ◯ Y ◯ N
College: ◯ Y ◯ N Degree?_____

EMPLOYMENT HISTORY:

Employed now? ◯ Y ◯ N Year Last Employed: _____
Past types of employment/work performed:_____

ADULT RELATIONSHIPS:

Please Circle one: ◉ Single ◯ Divorced ◯ Widowed ◯ Significant Other ◯ Married ◯ Remarried
If divorced and remarried, at what age and how many times? _____

Do you have children: ◯ Y ◯ N How many children do you have?_____ Do they live with you: ◯ Y ◯ N

With whom do you live: ☐ Self ☐ Husband ☐ Wife ☐ Children ☐ Other:_____
How are you supported at present:_____

Please remember to complete a Release of Information(ROI) for anyone who will be a part of your treatment. You may request additional ROI's at the front desk.

Please Return To The Front Desk.
At the time of the first appointment, additional paperwork is required.
Please arrive a half an hour prior to your first appointment.

For Office Use Only

Diagnosis: _____ *Initial Tx:* _____
_____ _____
_____ _____
_____ _____
_____ _____

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