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Health Psychology Intake

Name_____ Date of Birth_____

How would you rate your health (circle one)? Excellent Good Fair Poor
Have you had a physical exam in the past year? Yes / No

Sleep:
How many hours of sleep do you get each night on average?_____
Do you feel that this is enough? Too much? Explain_____
Do you have trouble falling asleep or staying asleep or falling BACK TO SLEEP if woken in the middles of the night?

_____

Do you wake up feeling refreshed? Yes / No Do you take naps during the day? Yes / No

Nutrition:
Describe your nutrition or food in a typical day. Please include liquids, snacks, bars, condiments; when cooking, include salt, oils, spices, etc.

_____

_____

_____

_____

How many alcoholic drinks per week do you have? _____

Exercise:
How many times a week do you exercise? _____ For how long each time? _____
What forms of exercise do you do? _____

Medications and Substances:
Do you smoke anything, vape, etc.? Yes / No If yes, how much a week?_____
Have you ever tried to quit? Yes / No If yes, how many times?_____
Please list street drugs and history of use: _____

_____

Screentime and Media:
How many hours a day do you look at a screen in the following forms?

_____ Smart Phone _____ Video games _____ Computer _____ Television _____ Other
Are you now or have you been recently involved in any legal matters or lawsuits? Yes / No

Health Concerns, Symptoms, Treatments & Therapies:
List any surgeries or medical procedures that you have had and their outcomes:
Year Type Outcome

_____

_____

List current and past medical conditions:_____

_____

List pain medications and dosages (includes opiates, NSAIDS, Tylenol, tranquilizers, etc.):

_____

_____

List other medications and dosages, prescribed or not prescribed, including vitamins, natural herbs, over the counter medications, and street drugs:

_____

_____

List alternative and complementary treatments that you have tried such as acupuncture, chiropractic, music therapy, tai chi, and herbal remedies. Were these helpful?

_____

_____

Check any of the following symptoms that you have experienced in the past *month*:

Physical:

Hearing Voices	_____	Constipation	_____	Headaches	_____	Rash	_____
Seeing Things	_____	Diarrhea	_____	Shakiness	_____	Pain	_____
Blurred Vision	_____	Dizziness	_____	Chronic Fatigue	_____	Nausea	_____
Weight Loss/Gain	_____	Hypertension	_____	Change in Sleep	_____	Sweating	_____
Breathing Difficulty	_____	Fast/Slow speech	_____	Addictive behaviors	_____		
Heart Palpitations	_____	Shortness of breath	_____	Chills or hot flashes	_____		
Restricting/Overeating	_____	Binging/Purging	_____	Non-epileptic seizures	_____		

Emotional/Mental:

Sadness	_____	Mania	_____	Lack of interest in usual things	_____
Euphoria	_____	Irritability	_____	Change in Libido	_____
Impulsivity	_____	Suicidal thoughts	___	Homicidal Thoughts	_____
Worry	_____	Poor memory	_____	Poor Concentration	_____
Delusions	_____	Worthlessness	_____	Racing Thoughts	_____
Disoriented	_____	Sensitive	_____	Emotional Eating/Stuffing Feelings	_____
Panic Attacks	_____	Agitation	_____	Being triggered	_____
Dissociation	_____	Flashbacks	_____	Avoiding things or people	_____
Nightmares	_____				

Past mental health diagnoses you have had or think you may have had (ex. ADHD, depression, bipolar): _____

_____

Family History:
List history of family members with mental or physical illnesses (eg. depression, anxiety, suicide, gambling problem)

_____

_____

Tell me about your family: parents/caregivers, siblings, other people you were raised with:

_____

_____

Strengths and Coping Skills:
List ways that you relax, cope with stress, re-energize yourself, hobbies:_____

_____

Do you have a support network (family, friends, co-workers)?_____

_____

What is your biggest achievement?: _____

What are your goals for therapy and why seek therapy now? _____

_____

_____