

# Del Mar Psychiatric Center

1343 Stratford Court, Del Mar, CA 92014  
858-523-9409 phone, 858-523-9403 fax

## Intake Questionnaire

In order for us to provide comprehensive care, please fill out the following intake form and questionnaires to the best of your ability. We realize there is a lot of information and you may not remember or have access to all of it; do the best you can. If there is information you do not want in your medical chart or is inapplicable, it is fine to leave it out. Thank you!

**DATE OF FIRST VISIT** \_\_\_\_\_

**MAIN PURPOSE OF THE CONSULTATION** (Please give a brief summary of the main problems)

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**WHY DID YOU SEEK THE EVALUATION AT THIS TIME?** (What are your goals in being here?)

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**CURRENT LIFE STRESSES** (include anything that is currently stressful for you, examples include relationships, job, school, finances, children) \_\_\_\_\_

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### **FAMILY INFORMATION**

Relationship Status:  Single  Married  Domestic Partner  Separated  Divorced  Widowed

Name of Spouse/Partner: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Children Name(s) \_\_\_\_\_ Date(s) of Birth: \_\_\_\_\_

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Patient name \_\_\_\_\_

Who do you currently live with? (persons & pets): \_\_\_\_\_

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**Current Marital or Relational Satisfaction** \_\_\_\_\_

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**PRIOR PSYCHIATRIC HISTORY/ PRIOR ATTEMPTS TO CORRECT PROBLEMS**

(Please include contact with other professionals, medications, types of treatment, etc.)

DATE \_\_\_\_\_ PROBLEM \_\_\_\_\_

DATE \_\_\_\_\_ PROBLEM \_\_\_\_\_

DATE \_\_\_\_\_ PROBLEM \_\_\_\_\_

DATE \_\_\_\_\_ PROBLEM \_\_\_\_\_

History of baby blues? \_\_\_\_\_ postpartum depression? \_\_\_\_\_

**FAMILY PSYCHIATRIC HISTORY**

Family Member _____	Problem _____	Dates _____
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_____	_____	_____
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_____	_____	_____
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_____	_____	_____
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**Significant Developmental Events** (marriages, separations, divorces, deaths, traumatic events, losses, abuse)

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**Current Employment/Profession and Satisfaction** \_\_\_\_\_

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**Past Employment/Profession (if applicable):** \_\_\_\_\_

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**Alcohol and Drug History:**

Ever experience withdrawal symptoms from alcohol or drugs? \_\_\_\_\_

Has anyone told you they thought you had a problem with drugs or alcohol? \_\_\_\_\_

Have you ever felt guilty about your drug or alcohol use? \_\_\_\_\_

Have you ever felt annoyed when someone talked to you about your drug or alcohol use? \_\_\_\_\_

Have you ever used drugs or alcohol first thing in the morning? \_\_\_\_\_

Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate) \_\_\_\_\_

Patients Name \_\_\_\_\_

**Alcohol and Drug History Continued:**

Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew) \_\_\_\_\_

Alcohol use per day/week \_\_\_\_\_

Illegal Drug Use (recreational) \_\_\_\_\_

**Sexual history:** (answer only as much as you feel comfortable)

History of sexual abuse, molestation or rape? \_\_\_\_\_

Current sexual problems? \_\_\_\_\_

Any history of being physically abused? \_\_\_\_\_

**MEDICAL HISTORY**

Other doctors/clinics seen regularly: \_\_\_\_\_

Any history of head trauma? (describe): \_\_\_\_\_

Ever any seizures or seizure like activity? \_\_\_\_\_

Prior hospitalizations (place, cause, date, outcome): \_\_\_\_\_

Prior abnormal lab tests, X-rays, EEG, etc: \_\_\_\_\_

Allergies/drug intolerances (**describe**): \_\_\_\_\_

Medicines currently taking (including over-the-counter): \_\_\_\_\_

\_\_\_\_\_

Please approximate present height and weight: \_\_\_\_\_

**Sleep behavior:** insomnia, interrupted sleep, overly sleepy, recurrent dreams/nightmares,

\_\_\_\_\_

\_\_\_\_\_

**SELF ASSESSMENT**

**Describe your relationships with friends/family** \_\_\_\_\_

\_\_\_\_\_

**Describe yourself** \_\_\_\_\_

\_\_\_\_\_

**Describe your strengths** \_\_\_\_\_

\_\_\_\_\_

**Describe your weaknesses** \_\_\_\_\_

\_\_\_\_\_