

Chesapeake Center
Adult Intake Form

In order to facilitate your first consultation at the Chesapeake Center, please complete the following form prior to your initial consultation. You may FAX it to us at 301-562-8449 – please be sure to write the name of the Chesapeake Associate you will be seeing on your form. Or, you may bring it to your initial consultation.

If you have any questions about how to answer certain items, you should circle them and discuss your questions with the Chesapeake associate with whom you are consulting.

If you are unable to recall or don't know the answer to specific questions, please write **DK** for "don't know" as your answer.

Name: _____

Date: _____

Age: _____

Educational level: _____

Marital status: _____ Single
 _____ Married
 _____ Remarried
 _____ Divorced
 _____ Spouse deceased

Name of Chesapeake Associate with whom you have scheduled a consultation:

Reason(s) for seeking this consultation:

Referred by:

Name: _____

Phone: _____

Address: _____

Are you currently in psychological/psychiatric treatment?

Name: _____ Phone: _____

Address: _____ FAX: _____

Name: _____ Phone: _____

Address: _____ FAX: _____

May we have your permission to communicate with this (these) person(s)? Y___ N___

Are you currently taking any psychotropic medications? Please list them below:

Name _____

Dose (mg.) _____

Frequency _____

Name _____

Dose (mg.) _____

Frequency _____

Name _____

Dose (mg.) _____

Frequency _____

Name _____

Dose (mg.) _____

Frequency _____

Name of physician (s) prescribing your current medications:

_____ Phone: _____

Please list all medications that you have been prescribed in the past accompanied by information about its effectiveness, side-effects, and why you are no longer taking it:

Name of medication: _____

Notes: _____

Name of medication: _____

Notes: _____

Name of medication: _____

Notes: _____

Your family of origin: (parents and siblings)

| | Name | Age | Living/ Deceased | Educational Level | Profession |
|---------|-------|-----|---------------------|----------------------|------------|
| Father | _____ | | | | |
| Mother | _____ | | | | |
| Sibling | _____ | | | | |
| Sibling | _____ | | | | |
| Sibling | _____ | | | | |
| Sibling | _____ | | | | |

Current family: (your spouse/significant other and any children)

| | Age | Lives where? | Educational Level | Profession |
|------------------------------|-------|--------------|-------------------|------------|
| Spouse/ Significant Other | _____ | | | |
| Child | _____ | | | |
| Child | _____ | | | |
| Child | _____ | | | |
| Child | _____ | | | |

Use additional space, if needed.

Family psychiatric history:

Please list any members of your family that suffered from any of the conditions listed below. If a family member was never officially diagnosed, but in your judgment struggled with a condition, please mention this as well.

| Condition | Family member(s) (relationship to you) |
|-------------------------------------|---|
| Anxiety | _____ |
| Obsessive/compulsive disorder (OCD) | _____ |
| Post-traumatic stress disorder | _____ |
| Depression | _____ |
| Bipolar Disorder | _____ |
| ADD/ADHD | _____ |
| Learning Disability | _____ |
| Substance abuse | _____ |
| Eating disorder | _____ |
| Suicide/suicide attempt | _____ |
| Psychiatric hospitalization | _____ |
| Violent or aggressive behavior | _____ |
| Seizure disorder | _____ |
| Other | _____ |

Is any member of your family currently in psychological and/or psychiatric treatment?

Name: _____

Treating Professional: _____

Name: _____

Treating Professional: _____

Childhood history:

(Please answer the following questions as best you can – we understand that you may not have all of the information requested.)

Yes No

___ ___ Pre-natal problems – please describe: _____

___ ___ Birth complications – please describe: _____

___ ___ Premature at birth – Number of weeks _____

___ ___ Unusual health problems in early childhood – please describe

___ ___ _____
Developmental milestones normal - walking, talking?
If not, please describe: _____

___ ___ Irritable or colicky as a baby?

___ ___ Overactive

___ ___ Underactive

___ ___ Problems with thumb sucking

___ ___ Problems with bed-wetting

___ ___ Behavioral problems

Please tell us in your own words how your mother described you as a baby or toddler:

Medical history:

Yes No Condition

___ ___ Allergies

___ ___ History of severe ear infections

___ ___ History of accidents requiring trips to the ER – please describe

___ ___ Seizures

___ ___ Head injuries (please list all head injuries, even minor ones)

___ ___ _____
Thyroid problems

___ ___ Hypoglycemia

___ ___ Diabetes

___ ___ Other – please describe

For women only:

- ___ ___ Significant problems with PMS (pre-menstrual syndrome)
- ___ ___ PMDD (Premenstrual Dysthymic Disorder)
- ___ ___ Problems related to peri-menopause
- ___ ___ Problems related to menopause
- ___ ___ Take hormone replacement

Eating disorders

- ___ ___ Anorexia
- ___ ___ Bulimia
- ___ ___ Compulsive overeating
- ___ ___ Binge eating
- ___ ___ Inpatient treatment for eating disorder
- ___ ___ Outpatient treatment for eating disorder

Addictive patterns

- ___ ___ Cigarette smoking – now or in the past (please describe)

- ___ ___ Alcoholism
- ___ ___ Binge drinking
- ___ ___ Other drug/substance abuse – please describe

- ___ ___ Inpatient treatment for substance abuse
- ___ ___ Outpatient treatment for substance abuse
- ___ ___ Active member of Alcoholics Anonymous?

Sleep problems

- ___ ___ Chronic difficulty falling asleep at “normal” bedtime (11 PM-Midnight)
- ___ ___ Chronic night-owl
- ___ ___ Chronic sleep deprivation (less than 5.5 hours of sleep per night)
- ___ ___ Problems staying asleep
- ___ ___ Take medication for sleep (please describe) _____
- ___ ___ Sleep apnea?

Academic history:

- ___ ___ Academic problems in elementary school?
- ___ ___ Previously diagnosed with learning disabilities? Please describe:

- ___ ___ Previously diagnosed with ADD/ADHD? Please describe:

- ___ ___ History of behavior problems in school
- ___ ___ Difficulty with handwriting in early grades
- ___ ___ Difficulty with reading in early grades
- ___ ___ Difficulty with writing papers
- ___ ___ Problems with spelling
- ___ ___ Considered "bright, but unmotivated"
- ___ ___ Achieved less academically than parents or siblings?
- ___ ___ Pattern of highly variable grades?
- ___ ___ Required to repeat a grade?
- ___ ___ Attended public schools
- ___ ___ Attended private schools
- ___ ___ Gifted? Participated in a gifted and talented program in school?
- ___ ___ High school graduate?
- ___ ___ College graduate? (if partially completed college students, please discuss)
- ___ ___
- ___ ___ Graduate degrees? _____

Work history:

- _____ Number of years in workforce since leaving school/college
- _____ Number of different jobs (not counting part-time jobs during school years)

Yes No

- ___ ___ Fired/terminated/laid off due to unsatisfactory work performance
- ___ ___ Periods of unemployment –
How many? _____ How long? _____
- ___ ___ Unsatisfied with current job/career?
- ___ ___ History of short-lived jobs?
- ___ ___ Repeated difficulties with supervisors
- ___ ___ Repeated difficulties with co-workers
- ___ ___ Chronic problems with deadlines and paperwork requirements?
- ___ ___ Chronic problems with being on-time
- ___ ___ Problems with disorganization

Please use this space below to tell us about anything you believe is important for us to know in order to help you with your current concerns:
