REAGAN OBIOZOR ANUSIONWU, NP IN PSYCHIATRY LLC
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RENEWED APPROACH TOWARDS ACHIEVING AND MAINTAINING OPTIMAL MENTAL HEALTH.

Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.

Personal Information

Name:____ Date: _____________________
Parent/Legal Guardian (if under 18): ____
Address: ____
Phone # : ___ ______________________________ May we leave a message? □ Yes □ No
Email: ______________________________________ May we leave a message? □ Yes □ No
**Please note: Email correspondence is not considered to be a confidential medium of communication.*

DOB: _____________________________ Age: ______ Gender: _______________
Martial Status:
□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Reason for Appointment Request: ____

List all your Current Symptoms:
1.__________________ 2. _________________
3. __________________ 4. _________________

PSYCHIATRIC HISTORY

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes,

If YES:

HOW OLD WERE YOU WHEN YOU FIRST HAD MENTAL HEALTH SERVICES? __________

NAME OF THE LAST MENTAL HEALTH PROVIDER YOU SAW? ________________________

DATE OF LAST SEVRICE: ________________________________

Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No

If yes, please list and provide

NAME	MG (Amount)	DATE OF LAST USED
1.__________	__________	__________
2.__________	__________	__________
3.__________	__________	__________
4.__________	__________	__________
5.__________	__________	__________

ADMISSION HISTORY

Have you ever been admitted into a psychiatric Hospital? ☐ Yes ☐ No

If yes, please list

	NAME OF HOSPITAL	*DATE OF ADMISSIONS:*
1.	__________	__________
2.	__________	__________
3.	__________	__________
4.	__________	__________

SUICIDAL HISTORY

Have you ever attempted to kill yourself? ☐ Yes ☐ No

If yes, please list

	TYPE OF ATTEMPT	*DATES OF ATTEMPT:*
1.	__________	__________
2.	__________	__________
3.	__________	__________

ABUSE HISTORY

Have you ever been Abuse (Sexually / physically / emotionally?) ☐ Yes ☐ No

If yes, please list what

	AGE OF ABUSE	*TYPE OF ABUSE*	*PERPETRATOR (ABUSER)*
1.	__________	__________	__________
2	__________	__________	__________
3	__________	__________	__________

SUBSTANCE ABUSE HISTORY

Have you ever used drugs (This includes cannabis)? □ Yes □ No

If yes, COMPLETE BELOW:

AGE OF FIRST DRUG USE: ____________________

TYPE OF DRUG(S) USE: ____________________

____

DATE OF LAST USE ____________________

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	____________
Anxiety	yes / no	____________
Depression	yes / no	____________
Domestic Violence	yes / no	____________
Eating Disorders	yes / no	____________
Obesity	yes / no	____________
Obsessive Compulsive Behavior	yes / no	____________
Schizophrenia	yes / no	____________
Suicide Attempts	yes / no	____________

Personal Information

1. Are you currently employed? □ No □ Yes

   If yes,

NAME OF EMPLOYER	***JOB TITLE***	***HOW LONG HAVE YOU BEEN EMPLOYED***
____________	____________	____________

1. How many siblings do you have? ____________
2. What is your highest level of education? ____________
3. Where were you born? ____________
4. Who raised you as a child? ____________

INCARCERATION HISTORY

Have you ever been incarcerated? □ Yes □ No

If yes,

TYPE OF CHARGE	DATE OF CHARGE
______________________	______________________
______________________	______________________
______________________	______________________

MEDICAL HISTORY:

Do you have any Medical History? Such as (*Diabetes, Asthma, HIV, HTN*) □ Yes □ No

If yes,

TYPE OF MEDICAL HX	*MEDICATIONS PRESCRIBED*
1.______________________	______________________
2.______________________	______________________
3.______________________	______________________

ALLERGY HISTORY

Are you allergic to any medications? □ Yes □ No

If yes,

TYPE OF ALLERGY	*REACTION*
1.______________________	______________________
2.______________________	______________________
3.______________________	______________________

Emergency Contact Information

Who should we contact in case of an emergency? Please complete below:

NAME OF EMERGENCY CONTACT	*RELATIONSHIP*	*PHONE #*
1.______________	______________	______________
2.______________	______________	______________
3. ______________	______________	______________