INITIAL INTAKE INFORMATION QUESTIONNAIRE

Name: _____ Date of Birth: _____
Date: _____ Height ___ft__ in. Weight _____lbs.

Reason(s) for the consultation: (Circle all that apply)
ADHD · Alcohol · Anger · Anxiety · Apathy · Appetite · Attention · Avoidance · Behavioral · Bodily_issues · Delusions · Depression · Dysfunctional · Fatigue · Fears · Grieving · Guilt · Hallucinations · Insomnia · Isolation · Libido · Negativism · Obsessions · Panic · Prescriptions · Restlessness · Substances · Suicidality · Suspiciousness · Worries · Other

Referred By: (Circle) Family · Friend · Colleague · Employer · Professional · Doctor · Other

Which of areas of your life are currently affected? (Circle all that apply)
Friendships · Peer_relationships · Romantic_relationships · Marriage · Family · Situation · Employment · Financial · Personal_Loss · Interests · Hobbies · Physical_health · Self-care · Eating_Habits · Sleeping_habits · Sexual_functioning · Concentration · Temperament · Impulsivity · Legal_matters · Other

What types of interventions have been helpful to you? (Circle all that apply)
Exercise · Mindfulness · Self-help · Readings · Relaxation · Techniques · Counseling · Couple_or_group_therapy · Psychotherapy · Behavioral_therapy · Self-help_groups · Prescribed_Medications · Primary_Care_Provider · Psychiatrist · Recreational_substances · Detox/Rehab_program(s) · Other

Which of these non-prescribed substances have you been using? (Circle all that apply)
Coffee · Nicotine_E-cigarettes · Nicotine_vaping · Alcohol · Sober · CBD-use · Marijuana · Amphetamines · Cocaine · Hallucinogens · Narcotics · Inhalants · MDNA · Ecstasy · Intravenous · Other

Currently prescribed medications for a mental health reason: (Circle all that apply)
None · Antidepressant · Antianxiety · Stimulant · Antipsychotic · Pain_medication · Other
List of Medication(s) _____ Allergies Y/N (Specify)_____
Past Medication(s) Y/N (Specify)_____ Past Hospitalization(s) Y/N

Known history of medical or other conditions or prescribed medications?
Fevers · Covid-19 · Fatigue · Chronic · Pain · Migraines · Brain · Injury · Concussion · Meningitis · Encephalitis · Seizures · Tumors · Cancer · Surgeries · Thyroid · Endocrine_condition · Cardiac_condition · Arrhythmia · Heart_sounds · Liver_disease · Kidney_disease · Menstrual_abnormalities · Contraception · Bleeding_or_Clotting_disorders · Glaucoma · Asthma · Iron_deficiency · Vitamin_D_deficiency · Vitamin_B-12_deficiency · Other_condition(s) · Other_medication(s) (Specify)_____

Prescribed medication(s) and OTC remedies: (Specify)_____

Primary care provider? Practice: _____ Phone: _____

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What is your employment status? (Circle which applies)
Currently · Employed · Self_employed · Unemployed · Student · Homemaker · Military_service · Injured · Disabled · Multiple · Employments · Satisfied · Dissatisfied · Other (Specify)_____ Position Title: _____ For How Long?_____

What is your highest level of education achieved? (Circle all that apply)
High_school · Vocational · Undergraduate · Graduate · Post-graduate · Currently_enrolled · High_Achiever · Average_Achiever · Underachiever

Marital status: (Circle all that apply) Never_married · Married_once · Multiple_marriages · Divorced · Widowed · Satisfied · Dissatisfied · Other (Specify)_____

Where and with whom do you reside in your household? (Circle all that apply)
Apartment · House · Alone · Partner · Roommates · Young_children · Adult_children · Parent(s) · Other_family_member(s) · Pets · Plants · Other (Specify)_____

Where were you born? _____ Where did you grow up? _____

What is your family structure, situation and history? (Circle all that apply)
Single_parent · Parents_married · Parents_divorced · Parent(s)_alive · Stepfamily · Siblings · Stepsiblings · Youngest · Oldest · Middle · Other (Specify)_____

Family Member with Medical Illness(es) N / Y (Specify)_____
Family Member with Mental Illness(es) N / Y (Specify)_____

Early childhood or adolescent traumatic experiences? (Circle all that apply)
Parental_death(s) · Sibling_death · Parental_divorce · Separation_from_parent(s) · Multiple_family_relocations · Sibling_rivalry · Family_situation_difficulties · Other (Specify)_____

Do you have goals for your treatment?
Short-term goals: (Specify)_____
Long-term goals: (Specify)_____

Thank you utilizing my professional services.
Dr. Ronald Liteanu, M.D.