OPENED HEART THERAPY
INTAKE QUESTIONNAIRE

BASIC PERSONAL INFORMATION	
Name:	**Today's Date:**
Maiden Name (if applicable):	**Date of Birth:**
Address:	
Preferred Phone: (home / work / cell)	**May I leave a message at this number?** ◊ yes ◊ no
Alternative Phone: (home /work / cell)	**May I leave a message at this number?** ◊ yes ◊ no
Email: (please be aware that email may not be confidential)	
How did you learn about our practice?	
Occupation:	**Employment Status** (full- or part-time, unemployed, retired, etc.)**:**
Employer (if applicable):	
School (if applicable):	
Year in School and Program of Study (if applicable):	
Emergency Contact (and responsible person if you are under 18): Name: Relationship to you: Address: Phone:	

Military Experience? ◊ yes ◊ no

Branch: MOS:

Years of Service: Combat exposure: ◊ yes ◊ no

Rank at Discharge: Type of discharge:

Racial and Ethnic Background:

Sexual Orientation:

Spiritual and/or Religious Background:

Gender Identity and Preferred Pronouns:

History of Pregnancy and Labor:

Other important information about your background or values:

Children:

Name(s)	Age(s)	Living with you (Yes/No)?

MEDICAL HISTORY

How would you describe your current physical health (e.g., poor, okay, good, excellent):

Please describe any significant past medical problems and treatments (e.g., surgeries, problems in any of the following systems - immune, metabolic, respiratory, kidney and urinary, gastrointestinal, digestive, cardiovascular, nervous, muscle/bone/joint, reproductive):

Current Primary Care Physician's Name, Address, and Phone:

Do you wish to have your primary care physician contacted or involved in your mental health treatment?

◊ yes ◊ no

Please list any psychiatric and non-psychiatric medications you are currently taking:

Medication	Dosage	Reason for taking

Do you currently have a psychiatrist? ◊ yes ◊ no
If yes, please list name and contact info:

Have you been prescribed psychiatric medications in the past? ◊ yes ◊ no
If yes, please list medications:

Has anyone in your family had significant medical or psychiatric illnesses? ◊ yes ◊ no
If yes, please describe:

Please describe any past experience with outpatient therapy:

Therapist	Start/End Dates	Type of Treatment	Reasons for Seeking Treatment

Please describe any past experience in inpatient or day hospital programs:

Facility/Program	Start/End Dates	Type of Program	Reasons for Seeking Treatment

Substance Use History
How often and how much do you drink alcohol?
Do you believe your alcohol use may be a problem? ◊ yes ◊ no
Do you believe you ever had a problem with alcohol use in the past? ◊ yes ◊ no **If so, please describe:**
How often and how much do you use non-prescribed drugs?
Do you believe your drug use may be a problem? ◊ yes ◊ no
Do you believe you ever had a problem with drug use in the past? ◊ yes ◊ no **If so, please describe:**
Do you struggle with other coping behaviors that feel addictive such as smoking, gambling, pornography, over-exercising, over- or under-eating, etc.?

Nutritional Summary

	Breakfast	Lunch	Dinner	Snacks
Average Time				
Example of "best" snack/meal				
Example of "worst" snack/meal				

Amount of daily water intake:

Type/amount of intake of other fluids:

Food cravings:

Food allergies/intolerances/sensitivities:

Food preferences (circle all that apply): sweet sour salty bitter spicy

Do you prefer cooked foods or raw/cold foods?

Eating schedule/habits (include snacks, etc):

Typical eating environment (at home, at work, sitting, standing, while driving, etc…):

How often do you prepare your own food?

Frequency of consumption (how many servings/week)

_____coffee/caffeinated tea _____soda
_____alcoholic beverages _____sweets
_____eating out _____fresh fruits/vegetables
_____animal protein _____soy products
_____dairy _____gluten

Stress
How do you typically handle stress?

Do you have a relaxation and/or meditation program? If so, please describe type and frequency.

Specific stressors right now:

Favorite time of the day: Of year:

Favorite type of weather:

Exercise frequency, type, and duration:

Sleep:

	Bedtime	Wake Time
Weekday		
Weekend		

_____Sleep less than 6 hours/night _____Sleep more than 8 hours/night
_____ Bedtime routine _____Lying in bed waiting to sleep (how long?)
_____ Disruptive midnight waking _____Dreams

Emotional/Spiritual/Social health:

What are the predominant emotions in your life (circle all that apply)?

compassion	anger	rage	joy	nostalgia	love	grief
jealousy	sadness	worry	excitement	inspiration	fear	
anticipation	anxiety	emptiness	regret	apathy		

other:

How are your relationships . . .

With family:

With friends:

With your partner:

With your community:

Do you have a network for support you can call on?

What do you do for fun? What do you do to relax?

What in your life gives you a feeling of fulfillment?

I always wanted to be _____

I always wanted to do _____

Do you have a spiritual practice? What does it look like and what is its impact in your life?

Other Symptoms

Below is a list of behaviors and issues that are cause for concern for some people. Please mark any and all items that you think might apply to you. At the end of the list there is space to write any additional issues or concerns you might have.

o Aggression/violence	o Marijuana	o Issues from childhood
o Physical abuse	o Cocaine	o Hyperactivity
o Sexual abuse	o Prescription drugs	o Confusion
o Domestic violence	o Other illicit substances	o Sadness/Depression
o Anxiety/panic	o Restlessness	o Crying spells
o Sexual functioning difficulties	o Negativity	o Adultery/infidelity
o Parenting issues	o Difficulty forgiving	o Feeling empty/dissatisfied
o Suicidal thoughts/gestures	o Nightmares	o Feeling like a failure
o Marital problems	o Unemployment	o Body image
o Relationship problems	o Feeling tired/fatigued	o Gambling
o Compulsive behaviors (handwashing, checking, etc.)	o Self-injury (cutting, burning, scratching, pulling out hair)	o Phobias (germs, heights, confined places, etc.)
o Financial problems	o Easily distracted	o Loss/grief due to death
o Career-related problems	o Anger	o Impulsiveness
o Homicidal thoughts/gestures	o Hopelessness	o Difficulty at work
o Feeling spacey/detached from one's surroundings	o Partner/loved one's substance abuse	o Housework/home maintenance
o Loss of appetite	o Guilt	o Feelings of inferiority
o Sleep difficulty	o Obsessive thoughts/fears	o Trouble taking responsibility
o Attention/concentration	o Chronic headache	o Self-control
o Overeating	o Difficulty making decisions	o Lack of motivation
o Weight gain/loss	o Poor judgment	o Children with special needs (e.g., disabilities, medical conditions, behavioral problems)
o Eating disorder	o Procrastination	o Perfectionism
o Excessive worry	o Irritability	o Religion/spirituality
o Difficulty trusting others	o Trouble with authority	o Bad temper
o Low self-esteem	o Mood swings	o Separation/divorce
o Physical pain/discomfort	o Difficulty accepting/making changes	o Legal problems/court involvement
o Menstrual problems, PMS, menopause	o Overly concerned about what other people think	o Frequent conflicts with others
o Issues with elder parents	o Overly sensitive	o Cruelty/neglect of pets
o Lack of joy/satisfaction in life	o Hallucinations	o Alcohol
o Social withdrawal/isolation	o Medical issues	o Smoking
o Stress	o Risky/dangerous behavior	o Feeling disorganized
o Loneliness	o Few friends	o Identity issues
o Problems with employer/co-worker/employee	o Inappropriate/uncomfortable sexual thoughts/urges	o Crises of faith
o Complications or trauma during labor and/or delivery	o Complications or trauma during labor and/or delivery	
o Loss during pregnancy		
Other issues:		

TREATMENT GOALS

Please take a moment to review the issues you noted above. Which three items concern you the most? In other words, which three concerns would you most like to have addressed in your treatment? By the end of treatment, what would you like to be different?

1.

2.

3.

OTHER

Please describe anything else that is important to know in understanding your life and your difficulties.

Thank you so much for completing this Intake Questionnaire.
It will be very helpful in developing an organized and effective treatment plan.
Please let us know if you have any questions. We look forward to working with you!