

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 Conditions

		Allergies
		History of accidents requiring trips to the ER- <i>Please Describe Below</i>
		History of severe ear infections
		Seizures
		Head Injuries- <i>Please List all Head Injuries, even minor ones, below</i>
		Thyroid problems
		Hypoglycemia
		Diabetes
		Other- Please Describe :

Please describe any accidents to ER, head injuries or other significant history below:

For women only:

Yes	No	
___	___	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)
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___	___	Alcoholism
___	___	Binge drinking
___	___	Other drug/substance abuse – please describe
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___	___	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:

Yes No

- 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:

Yes No

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