Jennifer Lager, Psy.D.
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INTAKE QUESTIONNAIRE

Please answer all of the questions as best as you can. If you are uncertain about how to respond to a question, give your best answer or leave it blank. If you feel uncomfortable answering a question, you may leave it blank. Please bring the completed questionnaire with you to your first appointment.
Thank you.

Have you lost interest in previously loved activities?	Y	N
Do you have crying spells or feel like it?	Y	N
Do you feel sad or down	Y	N
Do you find it easy to make decisions?	Y	N
Have you noticed changes in your weight or appetite?	Y	N
Have you had a change in your interest in sex (increase/decrease)?	Y	N
Do you feel hopeful about the future?	Y	N
Are you more irritable than usual?	Y	N
Do you have trouble falling asleep or staying asleep?	Y	N
Do you have trouble remembering things?	Y	N
Do you have temper outburst that you cannot control?	Y	N
Do you feel others are to blame for most of your problems?	Y	N
Do you feel nervous or shaky inside?	Y	N
Do you often feel faint or dizzy	Y	N
Do you think that someone else can control your thoughts?	Y	N
Have you felt more self-confident than usual?	Y	N
Have you done things that are out of character for you?	Y	N
Have you had more energy than usual?	Y	N
Are you easily distracted so that you can't concentrate?	Y	N
Do your thoughts race?	Y	N
Do you have financial problems?	Y	N

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Do you interrupt others in conversation?	Y	N
Do you have trouble with time management?	Y	N
For your entire life, do you often start, but not finish, projects?	Y	N
Have you had lifelong trouble concentrating on tasks you find boring?	Y	N
Do you tend to lose items necessary to perform your daily activities?	Y	N
Do you function better in structured environments?	Y	N
Are you impulsive?	Y	N
Have you always had trouble with fidgeting or sitting still (even if you now control it)?	Y	N
Do you have difficulty slowing down/relaxing?	Y	N
Have you ever been concerned/felt guilty about your use of drugs/alcohol (D/A)?	Y	N
Has anyone else ever expressed concern about your use of D/A?	Y	N
Have you ever tried to stop using D/A or cut back for any reason?	Y	N
Have you ever woken up after a night of drinking and could not remember part of the evening?	Y	N
Have you ever drank in the morning?	Y	N
Have you searched for sexual material online?	Y	N
Have you participated in sex sites online?	Y	N
Have you ever believed that you needed to cut down on your use of the internet for sexual purposes?	Y	N
Do you lie to conceal your sexual behavior?	Y	N
Do you regret your sexual behavior afterwards?	Y	N
Do you feel that your sexual behavior is not normal?	Y	N
Have important parts of your life (job, family, friends, hobbies) been neglected because you were spending too much time on sex?	Y	N
Have you ever been arrested?	Y	N

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Do you believe that others would be better off if you were dead? Y N

Have you ever had a head injury? Y N

Do you have any medical problems? If yes, please list below Y N

Caffeine Use (current and past):

_____

Tobacco Use (current and past):

_____

Alcohol Use (current and past):

_____

Please list below all medications and dietary supplements that you are currently using (please go onto back of sheet if you need more room)

NAME	PURPOSE	DATE STARTED	DOCTOR PRESCRIBING

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PROBLEM AREAS	SELF	MOTHER	FATHER	SIBLING 1	SIBLING 2	YOUR CHILD	OTHER RELATIVE
Anxiety							
Panic Attacks							
Phobias							
Depression							
Seasonal Mood Changes							
Elevated Mood							
BiPolar Disorder							
Mania							
Irritability							
Anger/Rage Problems							
Self-Injurious Behavior							
Suicide Attempts							
Psychiatric Hospitalization							
Schizophrenia							
Hallucinations							
Psychosis							
Paranoia							
Delusions							
Grief							
ADHD							
Attention Difficulties							
Hyperactivity							
Intolerance of Boredom							
Learning/School Problems							
Juvenile Delinquency							
Defiant Behavior							
Bedwetting							
Fire Setting							
Cruelty to Animals							
Legal Problems							

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PROBLEM AREAS	SELF	MOTHER	FATHER	SIBLING 1	SIBLING 2	YOUR CHILD	OTHER RELATIVE
Obsessions or Compulsions							
Anorexia							
Bulimia							
Alcohol or Drug Abuse							
Dementia							
Head Injury							
Sleep Problems							
Nightmares							
Sleepwalking							
Physical Abuse-Victim							
Physical Abuse-Perpetrator							
Sexual Abuse-Victim							
Sexual Abuse-Perpetrator							
Autism							
Mental Retardation							
Developmental Disorder							
Sensitivity to Touch/ Sound							

Please list who, if anyone, you live with:

NAME AGE RELATIONSHIP

_____

_____

_____

_____

_____

_____

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Please briefly describe what is bringing you into therapy at this time, and what you hope to accomplish in therapy.