ALLISON HOLT & ASSOCIATES
CHILD, ADOLESCENT & ADULT PSYCHIATRY AND THERAPY
Change is within reach.

Allison Holt, MD
Angie O'Shea, MA, LMFT
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Tel **952-467-6214** Fax **952-467-6215**
261 School Avenue, Suite 220, Excelsior, MN 55331

Adult Clinic Intake Questionnaire

NOTE: Please download this form and open in Adobe Acrobat prior to completing. Please also limit your descriptions to 500 characters. Additional comments will be discussed at your appointment. Thank you.

Name: _____ Date: _____

DOB: _____ Age: _____ Legal Guardian if other than self: _____

Describe your typical day:

Do you drink alcohol? If yes, please describe:

Do you use street drugs? If yes, please describe:

Do you have any concerns about your diet or eating habits? (including eating disorders)

If you are having difficulties, who do you go to for support?

Religion: _____

Are you currently active in any church? ☐ Yes ☐ No

Do you find religion a support or a stressor in your life? Check the best answer:

☐ Support ☐ Stressor ☐ Neither

Medical History:

Primary doctor and/or clinic: _____ Date last seen: _____

Would you like us to share information with this provider? ☐ Yes ☐ No

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Medical Hospitalizations:

	Where:	Reason:	Date(s):
1.			
2.			
3.			
4.			
5.			

* Continue on the back of form if necessary

Please check any current health issues that apply to you and describe:

General	Eyes	Ears/Nose/ Mouth/Throat	Cardiovascular	Respiratory	Gastrointestinal	GenitoUrinary	GenitoUrinary
☐ weight	☐ blurry	☐ dry mouth	☐ chest pain	☐ shortness of breath	☐ heartburn	☐ hesitancy	☐ stiffness
☐ appetite	☐ flashes	☐ congestion	☐ dizziness	☐ cough	☐ nausea	☐ retention	☐ swelling
☐ fatigue	☐ dry	☐ headache	☐ swollen feet	☐ wheezing	☐ constipation	☐ menses	☐ aches
☐ poor sleep	☐ pain	☐ ringing	☐ leg cramps		☐ diarrhea	☐ sexual	☐ injury

Neurological	Skin	Endocrine	Hematological	Immunologic
☐ movements	☐ rash	☐ too cold	☐ bruising	☐ hives
☐ weakness	☐ itching	☐ too warm	☐ bleeding	☐ congested
☐ tremor	☐ dry	☐ sweating	☐ nodes	☐ infections
☐ seizure	☐ hair loss	☐ thirst	☐ anemia	☐ rashes

Describe checked symptoms or others not listed:

☐ None of the Above

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Do you have any other concerns about your current health? (pain, eating, mobility, etc):

1.

2.

3.

Current Medications:

Current Medications	When Started	Doctor/Prescriber	Effects

What psychiatric medications have you taken in the PAST, please list and describe in chronological order, if possible:

Past Medications	Dates/When Tried	Doctor/Prescriber	Effects

* Continue on the following page if necessary

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Past Medications	Dates/When Tried	Doctor/Prescriber	Effects

Allergies (please note any substances to which you are allergic and your reaction to them):

	Substance/Medication:	Reaction:
1.		
2.		
3.		
4.		
5.		

Surgeries (please note any surgerical procedures you have had):

	Reason:	Where:	Date:
1.			
2.			
3.			
4.			
5.			

* Continue on the back of form if necessary

Have you ever experienced a head injury? ☐ Yes ☐ No If yes, please explain

Have you ever experienced a seizure? ☐ Yes ☐ No If yes, please explain

Have you ever had meningitis or encephalitis? ☐ Yes ☐ No If so, when?

Have you ever been exposed to the Herpes Simplex virus? ☐ Yes ☐ No

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Do you smoke? ☐ Yes ☐ No If yes, how long? Amount

Family Psychiatric/Chemical Dependency History:

Are there any psychiatric or chemical dependency issues in your family? ☐ Yes ☐ No If yes, please describe

Who: Type of Illness:

1.
2.
3.

* Continue on the back of form if necessary

Social History:

Where were you raised and by whom?

Who was living in the household when you were growing up? (relationship including siblings, other relatives, friends, etc):

Did you get in trouble as a child/adolescent? If so, please describe:

Any legal issues in the past or present? If so, please describe:

Were you exposed to any type of abuse (sexual, physical, emotional, verbal, etc)? If so, please describe the type, by whom, duration:

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Educational Background

Years completed: Degrees/certificates/diplomas obtained:

Did you receive any special assistance/classes in school? If so, please explain:

Vocational/employment history:

Type of employment: Start Date: Duration: Why left?

1.

2.

3.

4.

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Marital Status: ☐ single ☐ married ☐ separated ☐ divorced

If divorced or separated, how long?

Any other significant relationships not resulting in marriage (describe when, how long):

Current living situation (who lives in the household, relationship):

Children (names and ages):

1.
2.
3.
4.
5.

* Continue on the back of form if necessary

Please list any other problems you feel are important:

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Please list questions you would like answered at this appointment if possible:

1.

2.

3.

4.

5.