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

Allison Holt, MD
Angie O'Shea, MA, LMFT
NURSE Becky Orpen, RN

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Tel **952-467-6214** Fax **952-467-6215**
261 School Avenue, Suite 220, Excelsior, MN 55331

NOTE: Please download this form, complete it, print and bring it with you to your appointment. Thank you.

Adult Clinic Intake Questionnaire

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.