

Name \_\_\_\_\_  
Date \_\_\_\_\_

INTAKE QUESTIONNAIRE  
Yaacov Jeffrey Kravitz, Ed.D., Licensed Psychologist

Please complete these questions as fully and as accurately as you can. Case records are strictly confidential.  
I. PERSONAL INFORMATION

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age:\_\_\_\_ Sex\_\_\_\_ Race\_\_\_\_  
Religion\_\_\_\_\_ Church/Synagogue member: yes \_\_ no \_\_  
Education: Years or grade completed\_\_\_\_ Degrees earned\_\_\_\_  
Occupation\_\_\_\_\_ How long in present job?\_\_\_\_\_

Have you had any counseling and/or psychiatric care? yes [ ] No [ ] If yes, when and under what circumstances:

Name of Dr. or counselor	Approximate Dates	What problem were you treated for?		

Who referred you to this psychologist or this group? \_\_\_\_\_

IN EMERGENCY PLEASE NOTIFY:

Name\_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ Zip \_\_\_\_\_

MARITAL INFORMATION

Present Marital Status: (check one): single [ ] engaged [ ] married [ ]  
separated [ ] divorced [ ] widowed [ ] unmarried couple [ ]

How long in present status?\_\_\_\_\_

Present mate: First name \_\_\_\_\_ Age \_\_\_\_\_  
Occupation \_\_\_\_\_ religion \_\_\_\_\_ Hobbies \_\_\_\_\_  
Comments about mate \_\_\_\_\_

Prior marriage length was \_\_\_\_\_ years. From 19\_\_\_\_ to 19\_\_\_\_

Prior mate: First name \_\_\_\_\_  
Occupation \_\_\_\_\_ religion \_\_\_\_\_ Hobbies \_\_\_\_\_  
(comments about mate \_\_\_\_\_)

Was this marriage broken by divorce [ ] or by the death [ ] of mate?

Give information about additional marriages on the reverse side of page.

CHILDREN:

First name:	Sex	Age	Descriptive comments
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who is currently living in your household? \_\_\_\_\_  
\_\_\_\_\_

Name \_\_\_\_\_  
Date \_\_\_\_\_

**FAMILY HISTORY**

Parents (names)    Mother \_\_\_\_\_                      Father \_\_\_\_\_  
Occupation \_\_\_\_\_  
Education \_\_\_\_\_  
Religion \_\_\_\_\_  
How do you get along? \_\_\_\_\_  
Parent's current marital status \_\_\_\_\_  
Current age or age at death \_\_\_\_\_  
If deceased, what was your age then? \_\_\_\_\_  
Comments \_\_\_\_\_

Sisters and brothers in chronological order (include yourself)

First name	Sex	Age	Descriptive comments
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Give any other information about your family that seems important (include suicide, chemical abuse, diagnosed mental illness, etc.) \_\_\_\_\_

Is there any history of abuse in your life? Yes [ ] No [ ]  
If yes, was it verbal [ ] emotional [ ] physical [ ] sexual [ ]

**II. GENERAL CURRENT HEALTH data.**

1) How much caffeine do you consume each day? (Give number of cups, size of typical cup, and amount of sugar per cup)

Coffee \_\_\_\_\_ cups \_\_\_\_\_ Oz/CUP \_\_\_\_\_ sugar  
tea \_\_\_\_\_ cups \_\_\_\_\_ Oz/CUP \_\_\_\_\_ sugar  
sodas/colas \_\_\_\_\_ Type \_\_\_\_\_

2) Cigarette use per day equals \_\_\_\_\_ cigarettes, or \_\_\_\_\_ packages.

a) Alcohol and drug consumption equals

Substance	Amount	How often ?	Age began	Last used
Wine				
Beer				
Hard liquor				
Drug(specify)				

4) List all known allergies (food, medications, environmental factors) including the reactions you experience. Please include any treatment and/or medications that you use to deal with your allergies:

5) What kind of exercise do you get? What is the frequency of your exercise?

What is the effect on you of this exercise?

How is most of your free time occupied?

6) What is your current height? \_\_\_\_\_ Weight \_\_\_\_\_  
In the last six months have you gained \_\_\_\_\_ weight or lost \_\_\_\_\_ weight?  
How much? \_\_\_\_\_ lbs. Reason \_\_\_\_\_

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7) Describe your daily diet. Include foods, drinks, snacks:

Breakfast:

Lunch:

Dinner:

Snacks:

8) Please list any medical conditions that you have now or have had in the past:

Medical Condition	Approximate Dates	Name of Dr. or counselor

9) List all medications you currently take. Please include dosage and condition being treated.

Please list all current medications (prescription/non-prescription/vitamins/herbs/other):

Name of medication	Dosage	Date started	What is it for?

What is the date of your last physical exam? \_\_\_\_\_

### III. INFORMATION ABOUT CURRENT CONCERNS

Why did you choose this time to seek counseling?

Has life been satisfying to you? Explain.

Additional thoughts or comments:

Name \_\_\_\_\_  
 Date \_\_\_\_\_

Below is a list of the ways you might have felt or behaved. Please check the boxes to tell me how often you have felt this way in the past week or so	Not at all	Less than 1 day/wk, 1-2 days/month	This Past Week			Nearly every day for 2 weeks	Do not write in this column
			1-2 days	3-4 days	5-7 days		
1. My appetite was poor.							
2. I could not shake off the blues.							
3. I had trouble keeping my mind on what I was doing.							
4. I felt depressed							
5. My sleep was restless							
6. I felt sad.							
7. I could not get going.							
8. Nothing made me happy							
9. I felt like a bad person							
10. I lost interest in my usual activities							
11. I slept much more than usual.							
12. I felt like I was moving too slowly.							
13. I felt fidgety (restless/inability to sit still)							
14. I wished I were dead							
15. I wanted to hurt myself							
16. I was tired all the time							
17. I did not like myself							
18. I lost a lot of weight without trying to.							
19. I had a lot of trouble getting to sleep							
20. I could not focus on the important things.							
21. I felt anxious,.							
22. I was unable to relax							
23. I had frightening thoughts, fantasies or day dreams.							
24. I felt stressed							
25. My body felt tight, OR I had shortness of breath, OR my heart raced.							
26. Irritable, poor control of temper							
27. Worry							
28. Difficulty controlling the worry							
29. Restlessness or feeling on edge							
30. Inability to control thoughts							
31. Can't make decisions							
32. Difficulty concentrating							
33. Racing thoughts							
34. Panic attacks							
35. Binge eating							
36. Pain							
37. Periods of confusion or disorientation							
38. Memory lapses, forgetfulness							
39. Thoughts of loss or trauma							
40. Fear of going crazy or out of control							
PLEASE CONTINUE ON THE NEXT PAGE							

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			1-2 days	3-4 days	5-7 days		
41. Problem with sexual functioning, decreased sex drive							
42. Muscle weakness or spasms							
43. Work conditions bad, Job problems							
44. Legal problems							
45. Medical problems							
46. Marital, home problems							
47. Financial problems							
48. Thoughts of loss or trauma							
49. Stomach problems							
50. Shakiness, dizziness, vertigo, unsteady							
51. Excessive guilt							
52. Feeling worthless							
53. Decrease in activity (work, social)							
54. Waking up unusually early							
55. Decreased need for sleep							
56. Increase in activity							
57. Hearing voices							
58. Crying spells							
59. Guilt							
60. Frequent or persistent head-ache							
61. Fearfulness							