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Patient Intake Packet

Dear Patient,

In this packet, you will find a number of questionnaires that will help us to learn more about you and your symptoms.

We specialize in cognitive-behavioral therapy or CBT. CBT differs from other forms of psychological therapy in several ways. First, CBT is an active therapy, meaning that you and your therapist will work toward reducing your symptoms. Second, whereas other treatments focus on understanding the reasons behind your symptoms, CBT emphasizes learning how to reduce and manage your symptoms. Third, CBT is designed to be time-limited rather than ongoing like some other forms of therapy.

CBT has been proven to be an effective treatment for many psychological problems including anxiety-related, eating-related, and mood-related symptoms. CBT focuses on teaching new skills and behaviors, helping you practice those skills in a variety of situations, learning healthier ways of coping with stressful situations, increasing awareness of the way you think in critical situations, and helping you make changes in your thinking patterns.

Your first few visits will consist of a comprehensive assessment of your problems. This is done in order to make sure that you receive the right kind of treatment. After the assessment, your therapist will recommend a course of treatment for you. You will have the opportunity to ask questions, and to decide whether you agree with the clinician's recommendations.

We want you to know as much as possible about your condition and the treatment you are receiving. Your therapist will provide you with information, but you are also encouraged to ask questions such as: What is the name of my condition? How common is it? What kinds of treatment are available for this condition? What evidence is there to show that this treatment will be helpful? We believe that people who are well informed will make the best choices and will benefit the most from treatment.

Confidentiality
All of the information that you provide to us, whether verbal, written, or on tape, is considered confidential by state law and by the ethical principles of the American Psychological Association. This means that if you are over the age of 18, information cannot be given out to other parties without your written permission. The exceptions to this rule are if there is an immediate risk of harm to you or to other people, or if your records are subpoenaed by a court of law.

Children
We regret that our staff cannot provide child care. Therefore, if you have young children, please arrange to have someone take care of them during your appointment.

If you have questions about content on the website, CBT, or other issues, please ask Dr. Marques.

Please sign below to indicate that you have read and agree with the above information and consent to the procedures described above:

_____ _____

Patient's Signature Date

Section 1: Basic Personal Information

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:
□ Single □ Living with Partner □ Widowed
□ Married □ Divorced or Separated □ Other

Please list any children/age: _____

Address: _____
(Street and Number)
_____
(City) (State) (Zip)

Home Phone: (____)_____ May we leave a message? □ Yes □ No

Cell/Other Phone: (____)_____ May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Ethnicity
□ Hispanic or Latino □ Not Hispanic or Latino

Race:
□ White □ Black or African American □ Native American/Alaska Native
□ Asian □ Native Hawaiian or Other Pacific Islander □ Other: _____

Employment Status:
□ Not Working □ Full-time □ Student
□ Part-time □ On disability □ Retired

What is your occupation (if applicable)? _____

What is your highest educational level?
□ Ph.D., MD, or equivalent □ BA, BS, or equivalent □ Some high school
□ MA, MS, or equivalent □ AA or some college □ Grammar school
□ Some Graduate School □ High School Graduate

Emergency Contact Person:

Name:_____

Relationship to you:_____

Address:_____

Their home phone number:_____

Their work phone number:_____ Their cell phone number or pager:_____

Section 2: Current Problem

Please describe the key problems for which you are currently seeking treatment, and when they began. Please feel free to note situations that are difficult for you, as well as problematic moods, thoughts, and behaviors.

_____

_____

_____

_____

_____

_____

_____

_____

SCREENING QUESTIONNAIRE

This form will ask you about problems that you may have had. Please respond to each question by circling "Yes," "No," or "Maybe/Unsure."

		CIRCLE ONE:		
1.	**PD:** Do you have times when you feel a sudden rush of intense fear or discomfort?	YES	NO	MAYBE/UNSURE
2.	**AG:** Do you feel panicky in any situations or avoid them because you might feel panicky?	YES	NO	MAYBE/UNSURE
3.	**AG:** Are you apprehensive about entering situations due to the fear that you may develop such symptoms as diarrhea, vomiting, dizziness, etc.?	YES	NO	MAYBE/UNSURE
4.	**SoP:** In social situations where you might be observed or evaluated by others or when you are meeting new people, do you feel fearful, anxious, or nervous?	YES	NO	MAYBE/UNSURE
5.	**SP:** Are you overly concerned that you may do and/or say something that might embarrass or humiliate yourself in front of others, or that others may think badly of you?	YES	NO	MAYBE/UNSURE
6.	**GAD:** Over the last several months, have you been continually worried or anxious about a number of events or activities in your daily life?	YES	NO	MAYBE/UNSURE
7.	**OCD:** Are you bothered by thoughts, images, or impulses that keep recurring to you that seem inappropriate or nonsensical but that you can't stop from coming into your mind?	YES	NO	MAYBE/UNSURE
8.	**OCD:** Do you feel driven to repeat some behavior or to repeat something in your mind over and over again to try to feel less uncomfortable?	YES	NO	MAYBE/UNSURE
9.	**SpP:** Do you fear or feel a need to avoid such things as flying, seeing blood, getting a shot, heights, closed places, or certain kinds of animals	YES	NO	MAYBE/UNSURE

or insects?

10. **PTSD:** Have you ever experienced or witnessed a traumatic or life-threatening event such as assault, rape, seeing someone badly injured or killed, combat, accidents, or natural or man-made disasters? YES NO MAYBE/UNSURE
11. **MDE:** Have you ever experienced a period of two weeks or more when you felt depressed, sad, empty, or lost interest or pleasure in your usual activities? YES NO MAYBE/UNSURE
12. **DyD:** Over the past two years, have you frequently had days where you felt down, blue, or depressed for most of the day? YES NO MAYBE/UNSURE
13. **MaE:** Have you ever experienced a period of several days or more when you felt unusually or excessively high or irritable? YES NO MAYBE/UNSURE
14. **Hyp:** Over the last several months, have you continually feared or believed that you might have a serious physical disease or illness? YES NO MAYBE/UNSURE
15. **Som:** Have you had a lot of physical problems in your life? YES NO MAYBE/UNSURE
16. **MixAD:** Do you often have days when you feel somewhat down or depressed or maybe anxious or keyed up? YES NO MAYBE/UNSURE
17. **ETOH:** Has there ever been a period of time when you drank too much alcohol? YES NO MAYBE/UNSURE
18. **SA:** Do you drink a large amount of beverages that contain caffeine? YES NO MAYBE/UNSURE
19. **SA:** Have you ever used any other substances such as marijuana or cocaine? YES NO MAYBE/UNSURE
20. **Conv:** Have you ever experienced a loss or change in your physical functioning such as paralysis, seizures, or severe pain? YES NO MAYBE/UNSURE
21. **Psy:** Has there ever been a period of time when you had strange or unusual experiences such as hearing or seeing things that other people didn't notice, hearing voices when no one was around, or seeing visions that no one else saw? YES NO MAYBE/UNSURE
22. **Psy:** Has there ever been a period of time when you had the feeling that something odd was going on around you, that people were doing things to test you or antagonize or hurt you so that you felt you had to be on guard constantly? YES NO MAYBE/UNSURE

DASS

Name: *Date:*

Please read each statement and circle a number 0, 1, 2 or 3 that indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found myself getting upset by quite trivial things.	0	1	2	3
2	I was aware of dryness of my mouth.	0	1	2	3
3	I couldn't seem to experience any positive feeling at all.	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion).	0	1	2	3
5	I just couldn't seem to get going.	0	1	2	3
6	I tended to over-react to situations.	0	1	2	3
7	I had a feeling of shakiness (eg, legs going to give way).	0	1	2	3
8	I found it difficult to relax.	0	1	2	3
9	I found myself in situations that made me so anxious I was most relieved when they ended.	0	1	2	3
10	I felt that I had nothing to look forward to.	0	1	2	3
11	I found myself getting upset rather easily.	0	1	2	3
12	I felt that I was using a lot of nervous energy.	0	1	2	3
13	I felt sad and depressed.	0	1	2	3
14	I found myself getting impatient when I was delayed in any way (eg, elevators, traffic lights, being kept waiting).	0	1	2	3
15	I had a feeling of faintness.	0	1	2	3
16	I felt that I had lost interest in just about everything.	0	1	2	3
17	I felt I wasn't worth much as a person.	0	1	2	3
18	I felt that I was rather touchy.	0	1	2	3
19	I perspired noticeably (eg, hands sweaty) in the absence of high temperatures or physical exertion.	0	1	2	3
20	I felt scared without any good reason.	0	1	2	3
21	I felt that life wasn't worthwhile.	0	1	2	3

Reminder of rating scale:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

22	I found it hard to wind down.	0	1	2	3
23	I had difficulty in swallowing.	0	1	2	3
24	I couldn't seem to get any enjoyment out of the things I did.	0	1	2	3
25	I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat).	0	1	2	3
26	I felt down-hearted and blue.	0	1	2	3
27	I found that I was very irritable.	0	1	2	3
28	I felt I was close to panic.	0	1	2	3
29	I found it hard to calm down after something upset me.	0	1	2	3
30	I feared that I would be "thrown" by some trivial but unfamiliar task.	0	1	2	3
31	I was unable to become enthusiastic about anything.	0	1	2	3
32	I found it difficult to tolerate interruptions to what I was doing.	0	1	2	3
33	I was in a state of nervous tension.	0	1	2	3
34	I felt I was pretty worthless.	0	1	2	3
35	I was intolerant of anything that kept me from getting on with what I was doing.	0	1	2	3
36	I felt terrified.	0	1	2	3
37	I could see nothing in the future to be hopeful about.	0	1	2	3
38	I felt that life was meaningless.	0	1	2	3
39	I found myself getting agitated.	0	1	2	3
40	I was worried about situations in which I might panic and make a fool of myself.	0	1	2	3
41	I experienced trembling (e.g., in the hands).	0	1	2	3
42	I found it difficult to work up the initiative to do things.	0	1	2	3

AUDIT

Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we some questions about your use of alcohol. Your answers will remain confidential so please be honest.

Place an X in the box that best describes your answer to each question.

Questions	**0**	**1**	**2**	**3**	**4**	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Section 3: Psychological Treatment History

Please list all outpatient psychologists, psychiatrists, counselors, or therapists that you have had.

Dates	Clinician's Name	City and Phone Number	Did you receive therapy? (Check if yes)	Did you receive medication? (Check if yes)	May we contact this person? (Write YES or NO)

Please list all inpatient psychiatric hospitalizations that you have had.

Dates	Hospital	City and Phone Number	May we contact this hospital? (Write YES or NO)

Please list all medications you are currently taking (psychiatric only).

Medication	Highest Dose	How long have you taken the medication?	Who prescribes this medication?

Please list all medications you have taken in the past, but are no longer taking (psychiatric only).

Medication	Highest Dose	How long did you take the medication?	Who prescribed this medication?

Who **currently** prescribes your psychiatric medications?

_____

Your prescriber's office address and phone number:

_____

_____

_____

_____

NOTE: Please let me know if you would like me to consult with your medication prescriber at any point in treatment.

Section 4: Medical History

Please describe your current physical health:

_____

_____

_____

_____

_____

_____

_____

Please describe any significant past medical problems and treatments (e.g., surgeries):

_____

_____

_____

_____

_____

_____

Do you currently have a primary care physician? □ Yes □ No

If not, would you like a referral to a primary care physician? □ Yes □ No

Primary Care Physician's Name, Address, and Phone (if applicable):

_____

_____

_____

_____

_____

Do you wish to have your primary care physician contacted or involved in your mental health treatment?

□ Yes □ No

Please list any non-psychiatric medications you are currently taking using the categories below:

Medication *Dosage* *Reason for taking the medication (e.g., blood pressure)*

_____

_____

_____

_____

_____

_____