THE OCD & ANXIETY CENTER
1100 Jorie Blvd. Suite 132 Oak Brook, IL 60523 630-522-3124

Intake Questionnaire

Please be as detailed as you can within your level of comfort.
For fields that either do not apply to you, or that you do not feel comfortable answering, you may respond "n/a," "does not apply," etc.

Referral Information

How did you hear about The OCD & Anxiety Center? Please check all that apply.

- ☐ Internet Search
- ☐ Another Professional
- ☐ Friend
- ☐ Flyer/Business Card
- ☐ Other (please specify): ______________________________

General Information

Patient Name: ____
First Middle Last

Date of Birth: ________________________
Month Day Year

Gender: ☐ Male ☐ Female ☐ Other (please specify): ____________

Religious Affiliation: _________________________

Sexual Orientation: ☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual
☐ Bisexual ☐ Transexual ☐ Asexual ☐ Pansexual
☐ Unsure/Questioning ☐ Other (please specify): _______
☐ Prefer not to answer

Level of Education: ☐ High School graduate ☐ Undergraduate degree
☐ Graduate degree ☐ Currently attending school
☐ Other (please specify): ____________________________

Current Occupation: ______________________________

Level of Job Satisfaction (1 [very low] – 10 [very high]): __________

Past Occupation(s): ____

____

____

Have you ever served in the military? ☐ Yes ☐ No

If "Yes," which branch and when? If no longer serving, what type of discharge?

____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Legally Separated

☐ Divorced ☐ Widow(er)

If Divorced/Widow(er), please provide date(s) of divorce or death of spouse: ____

Name and age of Spouse/Significant Other: ________________________________

Spouse/Significant Other Occupation: ____

Relationship Satisfaction (1 [very low] – 10 [very high]): __________

Do you have children? ☐ Yes ☐ No

Names/ages of children: ____

____

____

____

Please describe any past/present involvement with the legal system (e.g., arrests, lawsuits, etc.)

____

____

____

____

Mental Health Information

Please check any of the following problem areas you have been experiencing recently:

☐ Feelings of guilt
☐ Aggressiveness
☐ Afraid of leaving house
☐ Memory loss
☐ Financial problems
☐ Restlessness
☐ Worry
☐ Uncontrolled temper
☐ Sleep walking
☐ Problems staying asleep
☐ Difficulty concentrating
☐ Medical problems
☐ Too much energy
☐ Afraid of work/school
☐ Problems falling asleep
☐ Trouble making decisions
☐ Sudden mood changes
☐ Feeling worthless

- ☐ Overly tired
- ☐ Stealing
- ☐ Hopeless about future
- ☐ Purging food
- ☐ Problems with family
- ☐ Feeling sad/down
- ☐ Feeling panicky
- ☐ Low self-esteem
- ☐ Lying
- ☐ Chest pains
- ☐ Intrusive thoughts
- ☐ Drug use/misuse
- ☐ Easily distracted
- ☐ Poor/No appetite
- ☐ Thoughts about death
- ☐ Binge-eating
- ☐ Hearing voices
- ☐ Ruminating about the past
- ☐ Nightmares
- ☐ Feeling jealous
- ☐ Shortness of breath
- ☐ Problems at home
- ☐ Feelings of unreality
- ☐ Compulsive behaviors
- ☐ Legal problems
- ☐ Blackouts
- ☐ Problems at work/school
- ☐ Over-eating
- ☐ Sleeping too much
- ☐ Food preoccupation
- ☐ Excessive crying
- ☐ Feeling anxious
- ☐ Feeling impatient
- ☐ Fast heartbeat
- ☐ Alcohol use
- ☐ Stomach problems
- ☐ Feeling lonely
- ☐ Problems with social life
- ☐ Medical problems
- ☐ Other (please specify): ______________________________

Please list current/previous psychiatric diagnoses:

____

Please list current medications, and name of prescribing physician:

____

Please list previous psychiatric care (therapy, medication treatment, hospitalizations):

____

Physical Health / Medical Information

How would you rate your current:

Overall health?	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Sleep pattern?	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Eating habits?	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Exercise routine?	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor

Please describe any problems you are having in the above areas:

Overall health: ______________________________

Sleep pattern: ______________________________

Eating habits: ______________________________

Exercise routine: ______________________________

Please list any medical conditions for which you are currently being treated:

____

____

Please list medications, along with prescribing physician:

____

____

Family Background and Childhood History

Please list everyone present in the home when you were growing up:

____

____

Please describe your childhood relationships with your family members:

____

____

____

____

Please describe your current relationships with your family members:

____

____

____

____

Please provide any other important information regarding your childhood/family:

____

____

____

____

If you ever been physically, emotionally, and/or sexually abused, or neglected, please describe (e.g., what type of abuse/neglect, when the abuse/neglect occurred, who abused/neglected you):

____

____

____

____

Please list any family history of mental health problems of which you are aware:

If there is a family history of suicide, please provide additional information:

Please list any family history of medical problems of which you are aware:

Treatment Goals and Other Information

Please indicate what you would like to achieve by participating in treatment.

Please provide any additional information you would like your Provider to know.

* * * * *

By signing below, I attest that the information provided above is accurate to the best of my knowledge.

Patient Signature (if over age 12) Date

Parent/Guardian Signature (Clients ages 12-17) Date