NHPP CBT Practice - Glen Oaks
Kaufmann Building
75-59 263rd Street
Glen Oaks, NY 11004
Phone: (718) 470-8755

Adult Pre-intake Questionnaire

Name of Patient: _____ Date completing form: ____/____/____

Date of Birth: ____/____/____ Age: _____

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

Preferred Pronouns: _____

Race/Ethnicity: _____

Current Address: _____

Marital Status: ☐ Single ☐ Married ☐ Unmarried, with a Committed Partner ☐ Widowed ☐ Divorced

Occupation**:** _____

Contact Information:

Home Phone:		☐ Preferred	May we leave a message? ☐ Yes ☐ No
Cell1:		☐ Preferred	May we leave a message? ☐ Yes ☐ No
			May we text? ☐ Yes ☐ No
Cell2:		☐ Preferred	May we leave a message? ☐ Yes ☐ No
			May we text? ☐ Yes ☐ No
Other:		☐ Preferred	May we leave a message? ☐ Yes ☐ No
Emergency Contact 1:	Name	Relationship	Phone
Emergency Contact 2:	Name	Relationship	Phone
Preferred Email:			May we email you? ☐ Yes ☐ No

Are you or your partner a Northwell Employee? ☐ Yes ☐ No

Referral Information & Reasons for Seeking Services

1. Referred by (if any): _____
   _____
2. Briefly describe the main reasons you are seeking help. Why were you referred? How long has this been a problem?_____
   _____
3. Current psychiatrist and phone number: _____
4. Current therapist name and phone number: _____

Mental Health History

5. History of Present Illness: Please list any **current** mental health diagnoses or problems:

_____

_____

6. Please list any **previous** mental health diagnoses or problems:

_____

7 Please list any **current** psychiatric medications, dosages, and the date started:

_____

8. Please list any **previous** psychiatric medications, dosages, and the dates started and stopped:

_____

9.. Have you ever been in psychotherapy? ☐ Yes ☐ No

If yes, please list the dates, type of psychotherapy, name of therapist, and the reasons for seeking psychotherapy:

_____

10. Have you ever been hospitalized for mental health issues or had any other intensive treatment for them? *If so, please list the location, dates, and reason(s):*

	Location	Date	Reason
a.			
b.			
c.			
d.			

Sometimes people get so distressed that they have thoughts about hurting or killing themselves or others.

	Safety Information		**If Yes, when did this happen?**		
		Never	**<6 mos**	**<12 mos**	**12+ mos**
11.	Have you ever expressed **thoughts** of wanting to hurt or kill **yourself**?				
12.	Have you ever attempted suicide?				
13.	If yes, how?				
14.	Have you ever significantly harmed **yourself** on purpose (i.e. cut, burn)?				
15.	If yes, how?				
16.	Have you ever expressed thoughts of wanting to seriously harm or kill **anyone else**?				
17.	Have you ever **attempted** to seriously harm or kill **anyone else**?				
18.	Have you ever physically assaulted anyone?				

19. Is there a gun at home? ☐ Yes ☐ No

20. If yes, how is the gun stored? _____

Medical History

21. Please list any current medical conditions you have: _____

22. Please list any current non-psychiatric medications, dosages, and the dates started: _____

23. Please list any major surgeries (year) you had: _____

_____

24. Please describe your current physical activities, if any: _____

_____

Family Mental Health History

25. Please list any family members who have struggled with any psychiatric or addiction issues. What are/were their mental health diagnoses?

Family Member	**Diagnoses**	**Family Member**	**Diagnoses**
Biological Mother		Paternal Grandparent 1	
Biological Father		Paternal Grandparent 2	
		Maternal Grandparent 1	
		Maternal Grandparent 2	
Family Member	**Diagnoses**	**Family Member**	**Diagnoses**
Sibling 1 (age, specify)		Other 1:	
Sibling 2 (age, specify)		Other 2:	
Sibling 3 (age, specify)		Other 3:	

Social, Psychosocial & Developmental History

26. Have you used substances such as alcohol, marijuana, or other drugs? If so, which? _____

_____

27. Pregnancy Information: Mother's Age at Your Birth_____ How long was pregnancy? _____

28. Birth complications: _____

29. Did you have any delays in walking or speaking? ☐ Yes ☐ No

30. Did you have any other developmental delays? *If so, please describe:* _____

_____

31. Are you sexually active? ☐ Yes ☐ No

Educational History

32. What is the highest grade level you completed?

☐ Unknown	☐ Some undergraduate studies
☐ No Formal Education	☐ Bachelor's Degree, major: _____
☐ High School Diploma OR GED	☐ Graduate Degree, in what subject: _____

☐ Grade: _____	

33. Are you currently a student? ☐ No ☐ Full Time ☐ Part Time

If you are a student, please describe your **current** academic performance: _____

_____

34. When you were in school, were you in a special education? ☐ Yes ☐ No

_____

35. If you are/were in special education, how many students were in your class?

_____

36. Have you ever had any learning difficulties or impairments? ☐ Yes ☐ No

37. If yes, please describe: _____

38. Have you ever undergone any psychological evaluations/assessments as a child or adult? ☐ Yes ☐ No

*(If so, **please bring a copy of the report to the intake session)***

39. If you received special education services, what kind of extra academic support did receive?

☐ Tutoring ☐ Small Class Size ☐ Counseling ☐ Extended Time

☐ Other: _____

40. Were you ever been bullied in school (*Please describe)*: _____

_____

_____

41. As a child/adolescent or adult do or did you experience any impairments in social skills? (*Please describe*):

_____

_____

42. As a child/adolescent, did you have any behavioral difficulties in school? (*Please describe*): _____

_____

_____

43. As a child/adolescent, did you exhibit any behavioral difficulties at home? (*Please describe)*: _____

_____

_____

44. Have you ever experienced a dangerous traumatic event? (*If so, please describe the event, and when it took place):*

_____

_____

_____

Personal and Social History

45. How are you doing socially? Are you making time for socializing with friends and/or family? _____

_____

46. What are your hobbies and interests? _____

_____

_____

47. Please describe your strengths: _____

_____

48. Do you have other siblings? *If so, please indicate genders and ages*: _____

_____

49. What is your current living situation? (*own/rent, house/apartment, with whom*): _____

_____

50. Culture: Please describe your culture, racial or ethnic identity, sexual oriental, spirituality/religion, & gender identity

_____

_____

51. How would you describe **your own** spirituality or religious faith affiliation, if any? (*Please specify*): _____

52. How do you hope you benefit from psychotherapy? _____

53. How will you know that psychotherapy is "working?"_____

_____

Socio-Economic History

54. Employment Status. Occupation: _____

☐ Employed Part Time	☐ Unemployed & looking for work	☐ Homemaker
☐ Employed Full Time	☐ Unemployed & not looking for work	☐ Student
☐ Volunteer/Non-paid work position	☐ Professional Trainee	☐ Other: _____
☐ Retired	☐ On Disability/Unable to Work	

Household Composition

55. Who Lives with you? _____

_____

56. Family/Supports

	Name	Relationship	Quality of Relationship	Frequency of Contact	Comments
a.					
b.					
c.					
d.					
e.					
f.					

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

Patient Name: _____ **Date:** _____

PHQ9 (Depression): Over the ***last two weeks***, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed, or the opposite – being so fidgety or restless that you've been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or hurting yourself in some way	0	1	2	3
10. How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	*Not Difficult at All*	*Somewhat Difficult*	*Very Difficult*	*Extremely Difficult*
			PHQ9 Total:	

GAD7 (Anxiety): Over the ***last two weeks***, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
8. How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	*Not Difficult at All*	*Somewhat Difficult*	*Very Difficult*	*Extremely Difficult*
			GAD7 Total:	