

DR. MATHEW'S INTAKE QUESTIONNAIRE

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of birth \_\_\_\_\_

Phone number \_\_\_\_\_

What are your main reasons for wanting to be seen?

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How long has this been a problem?

Explain: \_\_\_\_\_

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Previous mental health care? Previous therapy? When and where?

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Previous psychiatric hospitalization? When and

where? \_\_\_\_\_

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Have you ever attempted

suicide? \_\_\_\_\_

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Is there any family history of mental health issues?

Explain: \_\_\_\_\_

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Personal current drug/alcohol use. Any substance abuse treatment? \_\_\_\_\_

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Current medical problems:

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Current medical problems continued:

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Where you delivered by C-Section?

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How was your health as a child? Illnesses and treatments, explain:

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Current medications and doses:

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Current supplements:

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Were you ever on oral contraceptives or long-term antibiotics?

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Any head injuries/concussions?

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Have you had any surgeries?

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Any toxic exposures? (metals, mold, infections, tick bites):

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Educational history:

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Living situation:

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Occupational history:

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Spiritual history:

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Stress reducing activities (exercise, relaxation):

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General eating habits, special diets, gluten free eating:

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Sleep habits:

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Support systems:

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