Monique R. Lowe PhD LLC
14205 SE 36th Street, Suite 100
Bellevue, WA 98006
Phone/425-454-2835 Fax/425-454-2315

Adult Intake Form

Patient's Name:	DOB:	Age:	
Religion:	Race:	Marital Status:	No. of children:
Address:	City/ST:	Zip:	County:
With whom are you currently living:			
Referral Source:	Phone:	Fax:	

MAIN PURPOSE OF THE CONSULTATION (Please give a brief summary of the main problems/symptoms):

How long have the above symptoms occurred?

WHY DID YOU SEEK THE EVALUATION AT THIS TIME? What are your goals in being here?

PRIOR ATTEMPTS TO CORRECT PROBLEMS/PRIOR PSYCHIATRIC HISTORY
(Please include contact with other professionals, medications, types of treatment, etc.)

Date:	Type of Treatment:	Medications:	Currently taking?	Effective?
			☐Y ☐N	☐Y ☐N
			☐Y ☐N	☐Y ☐N
			☐Y ☐N	☐Y ☐N
			☐Y ☐N	☐Y ☐N
			☐Y ☐N	☐Y ☐N

PRIOR DIAGNOSES:

MEDICAL HISTORY

Past/current medical conditions:

Currently being treated? ☐Y ☐N

Medications/vitamins/herbs:

Hospitalizations:

Date:	Cause:
Date:	cause:

NEUROPSYCHIATRIC HISTORY

Any history of head trauma, concussion, strokes or significant accidents? (describe):

Date:	Type of Accident/Diagnosis:	Hospitalization/Treatment?	Rehabilitation? Where?
		☐Y ☐N	☐Y ☐N

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		☐Y ☐N	☐Y ☐N
		☐Y ☐N	☐Y ☐N
History of seizures or seizure like activity? ☐Y ☐N		Date seizures began:	
Prior abnormal lab tests, X-rays, EEG, MRI, etc: ☐Y ☐N		Date tests conducted:	
Please bring pertinent medical records; lab results, MRI report, psychological testing, etc.			

DEVELOPMENTAL HISTORY

Months gestation?	Complications? ☐Y ☐N List: _____	Hours mom in labor:
Vaginal or Cesarean birth (circle one)	Estimated birth weight:	
Milestones (walk, talk, etc.) reached on time? ☐Y ☐N List if no:_____		

FAMILY HISTORY

No. of siblings in your childhood family?		Which number are you?	
Father's side		Mother's side	
Schizophrenia/psychosis	☐Y ☐N	Schizophrenia/psychosis	☐Y ☐N
Depression	☐Y ☐N	Depression	☐Y ☐N
Anxiety Disorder/OCD	☐Y ☐N	Anxiety Disorder/OCD	☐Y ☐N
Bipolar Disorder	☐Y ☐N	Bipolar Disorder	☐Y ☐N
Personality Disorder	☐Y ☐N	Personality Disorder	☐Y ☐N
Substance Abuse	☐Y ☐N	Substance Abuse	☐Y ☐N
Mental Retardation/LD	☐Y ☐N	Mental Retardation/LD	☐Y ☐N
Autism/Asperger's/PDD	☐Y ☐N	Autism/Asperger's/PDD	☐Y ☐N
Eating Disorder	☐Y ☐N	Eating Disorder	☐Y ☐N
History of abuse/neglect	☐Y ☐N	History of abuse/neglect	☐Y ☐N
Genetic Medical Condition	☐Y ☐N	Genetic Medical Condition	☐Y ☐N
Other _____		Other _____	
Dad deceased? ☐Y ☐N	Cause? _____	Mom deceased? ☐Y ☐N	Cause? _____

PSYCHOSOCIAL HISTORY

Number of marriages?	Number of biological children?	Number of stepchildren?	
History of substance abuse? ☐Y ☐N	Age abuse began?	Years sober or longest attempt at sobriety?	
Drug of choice:	Treatment received? ☐Y ☐N	Inpatient or Outpatient (circle applicable)	
Problems with sleeping? ☐Y ☐N	Explain:		
Problems with eating? ☐Y ☐N	Explain:		
Number of incarcerations:	Charges:	Years served:	
Other contact with the legal system: ☐Y ☐N	Explain:		
Currently employed? ☐Y ☐N	Years on job:	Longest time employed:	
Military service? ☐Y ☐N	Branch:	Years of service:	
History of physical/sexual abuse?	Age abuse began:	Treatment received? ☐Y ☐N	
History of mental abuse/neglect?	Age abuse began:	Treatment received? ☐Y ☐N	
Personal strengths:	Personal weaknesses:		
Current life stresses:			

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Explain coping strategies:			
EDUCATIONAL HISTORY			
Last grade completed:	Highest degree awarded:	Training/specialty:	
Special education: ☐Y ☐N	Gifted classes? ☐Y ☐ N	Behavior problems? ☐Y ☐N	Retained? ☐Y ☐N
Other problems in school? ☐Y ☐N	Explain:		
Average grades or G.P.A.:	Academic/achievement testing performed in school? ☐Y ☐N		

Patient Name: _____

Signature (Patient/Legal Guardian): _____

Today's Date: _____