USF Diabetes Center
Morsani Center, 5th Floor
13330 Laurel Dr.
Tampa, FL 33612

Psychology Intake Questionnaire

Please complete the following questionnaire and bring to your first appointment with Dr. Smith. This information will help Dr. Smith learn about your history and current difficulties.

Section I. Patient Identifying Information

Full name: _____ Gender: _____ Male _____ Female

Preferred name/nickname: _____ Date of Birth: _____

Address _____

City: _____ County: _____ State: ____ Zip: _____

Primary phone: _____ Can we leave a message? _____ Yes _____ No

Alternate phone: _____ Can we leave a message? _____ Yes _____ No

Section II. Background Information

Please list name, age, and relationship of all people living in your home:

	First Name	Age	Relationship to you
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Educational/Work History:

Highest grade/education completed: _____

Current occupation (if applicable): _____

Current employer (if applicable): _____

Hours worked per week: _____

Marital History:

Are you currently married? ____ Yes _____ No When did you marry? _____

If you have been married before, please list dates below:

From _____ To _____ (list additional dates for other marriages as needed)

Please list first names and ages of any children who do not currently live with you: _____

_____

Medical History:

When were you diagnosed with diabetes? _____

Please list any other medical conditions you have. _____

_____

Do you or anyone in your family have a history of mental health or learning problems such as depression, anxiety (nerves), ADHD, bipolar disorder, or another mental health concern? Please list family members and the condition they had/have.

_____

_____

_____

_____

What medications do you take? _____

_____

_____

Who is your primary care doctor? Doctor's Name: _____

Name of doctor's practice or office: _____

What doctor do you see for your diabetes? Doctor's Name: _____

Name of doctor's practice or office: _____

Section III. Current Concerns

Who referred you for psychological services? _____

Have you seen by a psychologist, counselor, social worker, or psychiatrist in the past? If yes, when and for what concern(s).

_____

_____

_____

Briefly describe the problem that brings you in for psychological services.

_____

_____

_____

_____

_____

_____