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**WELCOME! PLEASE COMPLETE THIS INITIAL INTAKE FORM**

Name: Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you come by referral? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Or on your own? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What brings you to this appointment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
What are the primary symptoms that you experience? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
What symptoms worry or bother you the most? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Have there been periods when it has been worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Have there been periods where it has been better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Has there been any change in frequency of symptoms? \_\_\_\_\_\_\_\_\_\_\_\_
Has there been any change in symptom intensity? \_\_\_\_\_\_\_\_\_\_\_\_
Has there been any change in symptom duration? \_\_\_\_\_\_\_\_\_\_\_\_
What tends to make the problem better? \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
What tends to make the problem worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
What might be the causing problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Have you ever sought treatment before? \_\_\_\_When? \_\_\_\_\_\_\_\_\_\_
With whom? How was it helpful?
Any previous Psychological Testing? What were the results?\_\_\_\_\_\_\_ \_\_\_\_\_\_

How would you like things to be different in 6 months? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY AND INFORMATION**

Please list any surgeries, hospitalizations, illness, or medical problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which specialists do you see currently? \_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medicines?

Please list any allergies to substances or foods: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please list **any/all medicines** you are taking **currently** (please use back of paper if necessary):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medicine | Dosage | Purpose | Start Date | Physician |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Please list here any medicines you have taken **in the past** (please use back of paper if necessary):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medicine | Dosage | Purpose | Start Date | Physician |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Any job-related injuries? \_\_\_\_\_\_\_\_\_\_\_\_

Any history of serious falls? No\_\_\_ Yes\_\_\_ When? \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Any history of seizures? N\_\_\_ Y\_\_\_ First onset? How treated? \_\_\_\_\_\_\_\_\_\_\_\_

Losses of consciousness? N\_\_\_ Y\_\_\_

If more than one incident, please indicate the following for each incident (use back of paper if necessary):

At what ages? \_\_\_\_\_\_\_\_\_\_\_\_

What happened? \_\_\_\_\_\_\_\_\_\_\_\_

Were you seen by a physician? \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Were you evaluated in the ER? \_\_\_\_\_\_
What changes (in personality or behavior) did you note after any of those incidents? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any auto accidents? \_\_\_\_Was alcohol involved?
Any history of electrical shocks? \_\_\_\_\_\_\_\_\_\_\_\_\_
Any exposure to toxic chemicals/solvents/work-place hazards? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **FAMILY HISTORY**

Any family history of the following being present on either your mother’s (put “M”) or father’s (put “F”) side of the family: Please include siblings, grandparents, aunts, uncles, cousins, nephews, nieces, offspring, etc. If any apply to you, now, or in the past, put an “S” for self.

Cancer \_\_\_\_\_\_\_\_ Diabetes \_\_\_\_\_\_\_\_ Hypertension \_\_\_\_\_\_\_\_ Heart disease \_\_\_\_\_\_\_\_ Heart Surgery\_\_\_\_\_\_\_\_ Stroke \_\_\_\_\_\_\_\_\_ Asthma \_\_\_\_\_\_\_\_\_ Lung/Other Breathing Problems\_\_\_\_\_\_\_\_\_\_ Kidney Problems\_\_\_\_\_\_\_\_\_ Hepatitis\_\_\_\_\_\_\_\_\_ Dementia\_\_\_\_\_\_\_\_\_ Hearing Impairment\_\_\_\_\_\_\_\_\_ Autoimmune Diseases\_\_\_\_\_\_\_\_\_ Manic Depression/Bipolar\_\_\_\_\_\_\_\_\_ Anxiety/Panic Attacks \_\_\_\_\_\_\_\_\_ Perfectionism \_\_\_\_\_\_\_\_\_
Depression Suicide Attempts\_\_\_\_\_\_\_\_\_ Psychiatric Hospitalizations\_\_\_\_\_\_\_\_\_ Drug Use \_\_\_\_\_\_\_\_\_
Obsessive Compulsive Disorder \_\_\_\_\_\_\_\_\_ Alcohol Problems\_\_\_\_\_\_\_\_\_ Post-Traumatic Stress\_\_\_\_\_\_\_\_\_ Attention Deficit Hyperactivity\_\_\_\_\_\_\_\_\_ Driving Under the Influence\_\_\_\_\_\_\_\_\_ Prison\_\_\_\_\_\_\_\_
Contact with the Law Learning Difficulties/Delays\_\_\_\_\_\_\_\_\_ Problems Completing School\_\_\_\_\_\_\_\_\_
On Disability\_\_\_\_\_\_\_\_\_ Other Addictions\_\_\_\_\_\_\_\_\_ Eating Disorders\_\_\_\_\_\_\_\_\_ Sexual Issues\_\_\_\_\_\_\_\_\_ Seizures\_\_\_\_\_\_\_\_\_ Epilepsy\_\_\_\_\_\_\_\_\_ Anger Problems\_\_\_\_\_\_\_\_\_ Prison\_\_\_\_\_\_\_\_\_ Sleep Problems\_\_\_\_\_\_\_\_\_
Significant Losses\_\_\_\_\_\_\_\_\_ Personality Problems\_\_\_\_\_\_\_\_\_ Traumatic Events\_\_\_\_\_\_\_\_\_ Divorce\_\_\_\_\_\_\_\_\_
Breaks with Reality\_\_\_\_\_\_\_\_\_ Extra-marital Affairs\_\_\_\_\_\_\_\_\_

History of: abuse, neglect, and/or molestation? \_\_\_\_\_\_\_\_\_\_\_\_

History of: rape and/or date rape? \_\_\_\_\_\_\_\_\_\_\_\_

Any other concerns on either side of the family? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anything you wish to add? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BACKGROUND DATA**

Where did you grow up? \_\_\_\_\_\_\_\_\_\_\_\_

What did your mother do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What did your father do? \_\_\_\_\_\_\_\_\_\_\_\_

Whom did you live with growing up? List all members and when you lived with them. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any serious health issues amongst your family members? \_\_\_\_\_\_\_\_\_\_\_\_

Did your parents stay together? \_\_\_\_\_\_ Or divorce?\_\_\_\_

If divorced, how old were you when they divorced? \_\_\_\_\_\_\_\_\_\_\_\_

How would you describe the post-divorce time for you? \_\_\_\_\_\_\_\_\_\_\_\_

For other family members? \_\_\_\_\_\_\_\_\_\_\_\_

Do you have siblings? Ages, and whereabouts now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To whom were you closest in the family while growing up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

And now? \_\_\_\_\_\_\_\_\_\_\_\_

How is your father’s health? \_\_\_\_\_\_\_\_\_\_\_\_

How is your mother’s health? \_\_\_\_\_\_\_\_\_\_\_\_

Did you grow up in a blended family? \_\_\_ When did that occur?\_\_\_\_\_\_\_\_\_\_

Do you use tobacco? \_\_ Form and Amount?\_\_\_\_\_\_\_\_

Do you use marijuana? How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you use as a teenager? When did you first start?\_\_\_\_\_\_\_\_\_\_\_\_

How often do you drink alcohol? When did you first start?\_\_\_\_\_\_\_\_\_\_\_

How often do you drink to excess? \_\_\_\_\_\_\_\_\_\_\_\_
Any current drug use? \_\_\_\_\_\_\_\_\_\_\_\_
Please circle any of the following you have tried in the past:

Amphetamines Cocaine Crack Ecstasy Heroin Uppers Sedatives Marijuana Mescaline Mushrooms Opium Hashish Designer drugs Cold remedies LSD
Over-the-Counter Medicines Glues/Paint/Fumes/Gasoline Huffing Ephedrine Muscle Relaxants Anabolic Steroids

Are you sexually active? Are you content in this area?\_\_\_\_\_\_\_ \_\_\_\_\_\_

Are you active spiritually? \_\_ Any formal affiliation with a religious group? \_\_\_\_\_\_

Is that a source of strength/support for you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a 1-10 scale, how important is your faith to you now? \_\_\_\_\_\_\_\_\_\_\_\_

Growing up? \_\_\_\_\_\_\_\_\_\_\_\_

To your family now? \_\_\_\_\_\_\_\_\_\_\_\_

To your family when you were growing up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELATIONSHIP STATUS**

Marital Status (circle one): Single Committed Relationship Married Divorced

Partner name and age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children’s name and ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you satisfied in your marriage/relationship?

Specific Concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there are questions not asked that you deem important about yourself, please give that information here. Also, please write on the back any particular questions you would like to be asked during the interview. I look forward to meeting with you! -Dr. Brock McKay, PhD

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_