DZ Counseling & Neurofeedback Training Services
Child, Adolescent, Adult, Couples & Family Counseling
501 Iron Bridge Road, Suite 15, Freehold, NJ 07728
Phone: 732-866-8611 ♦ Fax: 732-303-1221 ♦ www.dz-counseling.com

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Intake Questionnaire - Adult

Background Information

Please print clearly

Date: ____/______/_____

DOB: ____/______/________

Name: ____ Sex: ☐M or ☐F Gender ID Pref.: _________

Address: ____

City: ________________________________ State: __________ Zip: ______________________

Phone:___________________________________ Cell: ________________________________

Email: ____

Occupation: ___________________________ Employer: ____________________________________

Job Status: ☐FT / ☐PT Other____

Length of current Employment: ____

Relationship status: (please check) ☐single ☐married ☐divorced ☐partnered Widowed

Significant Other's Name: ____

Do you have any children? If yes, name and ages of children and whether biological, adoptive, or other:

____

____

With whom do they reside?

____

Others, including pets, residing with you:

____

MEDICAL HISTORY

Primary Physician: ____

Address: ____

City: ____________________________ State: ____________ Zip: _______________ Phone: _________________________________

Who referred you for evaluation /consultation: ____

Other treating physicians and specialties? ____

What concerns are you experiencing that made you seek counseling services at this time?

____

____

When did these concerns start? ____

____

What would you like to accomplish during this evaluation and from therapy/Neurofeedback?

____

____

Current medical problems, medications, and medication allergies:

____

____

Please list any hospital admissions or emergency room visits:

____

Date *Hospital* *Reason for Admission*

____

Date *Hospital* *Reason for Admission*

Please list any medications you are taking on a regular basis:

____

____

____

Has your hearing and vision ever been checked (circle) Yes or No If yes, where and what were the results?

____

____

Educational History

Level of education completed: ____

Did you experience any academic or behavioral difficulties during your school years?
____

____

Previous Psychiatric/Counseling Services

Please list all previous mental health services you have received:

Date	Type of Professional	Results/Experience comments

Are you or any other family members impacted by any of the following (check and indicate who)

☐ *Developmental delay* ☐ *Mental Retardation* ☐ *Learning disability*

☐ *ADHD* ☐ *Autism/PDD* ☐ *Seizure Disorder*

☐ *Anxiety* ☐ *Depression* ☐ *OCD*

☐ *Bipolar Disorder* ☐ *Eating Disorder* ☐ *Schizophrenia*

☐ *Substance Use* ☐ *Attempted/Completed Suicide* ☐ *Traumas*

Legal Issues or Other Concerns not listed: ____

Form Completed By: ______________________**Relationship to client:** ______________________

______________________ ____________ ______________________
Client's Name Date Client's Signature (14 yrs. and older)

<u>If a client is under the age of 18, Parent's/Legal Guardian's must sign</u>: I represent that I am a parent or legal guardian of the child identified in this form. I represent that I have full or shared legal authority to consent to the child's treatment and that the consent of no other person is required.

______________________ ____________ ______________________
Parent's/Legal Guardian's Name Date Parent's/Legal Guardian's Signature

______________________ ____________ ______________________
Parent's/Legal Guardian's Name Date Parent's/Legal Guardian's Signature