DZ Counseling/ Daniel Zykorie, LLC
Counseling and Neurofeedback Training
Children, Adolescent, Adults Couples & Families
501 Iron Bridge Road, Suite 15, Freehold, NJ 07728
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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

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 or therapy?
_____
_____
_____

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 Evaluations and Therapies

Please list all previous evaluations and therapies you have had:

Date	Type of Professional	Results/Experience comments

Is there anybody in the family with any of the following (check all that apply)

☐ *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: _____

Client Signature: _____ Date: _____

Name(s) of Other Person(s) Completing or Assisting in Completing Intake:

_____

These Named Other's Signature(s): _____
Date: _____