Adult Individual Intake Questionnaire

Thank you for completing this form and any others that you are given by *Sunlight Counseling, LLC*. The information you provide is confidential as outlined in *Sunlight Counseling, LLC* **Professional Disclosure** and **Notice of Privacy Practices** statements and will help your therapist create a treatment plan tailored to meet your needs and those of your family.

Date:_____/_____/_____

Name:____
(First) (MI) (Last)

Email:____ Date of Birth:____________ Age:_____

Address:____

May we leave a Message?

Telephone: (Home)___________________ Yes___ No___ (Cell)___________________ Yes___ No___

(Work)___________________ Yes___ No___

Emergency Contact: Please provide the name of the person to contact in case of emergency.

Name:__________________________________ Relationship to Client:____________________

Address:________________________________ Telephone #1:__________________________

________________________________ Alternate Telephone:____________________

Insurance Information

If using an insurance for payment, please provide your insurance card for photocopying.

Primary Insurance:_____________________________ Secondary Insurance:____________________

Employment (Check one) Full Time___ Part Time___ Self-Employed___ Unemployed___ Homemaker___ Other (please specify)____

Relationship Status (Check one) Single___ Engaged___ Cohabitating___ Significant Other___

Married___ Separated___ Divorced—How long ago?_________ Widowed—How long ago?_________

If Married—Is this your first marriage? Yes___ No___ If yes—How long have you been married?__________

If no—How many times have you been married before your current marriage?________________________

How many years have you been married to your current spouse?___________________________

Have you and your current spouse ever separated? Yes___ No___

If yes—When did you and your spouse separate?____________ For how long were you separated?_____

Education

Highest level of Education:____

Children

Name	Date of Birth	Age	Living with You	Other Parent's Name
First____________________________	_____________	____	Yes___ No___	____________________
Second__________________________	_____________	____	Yes___ No___	____________________
Third____________________________	_____________	____	Yes___ No___	____________________
Fourth___________________________	_____________	____	Yes___ No___	____________________
Fifth____________________________	_____________	____	Yes___ No___	____________________

Are there presently any Child Custody issues involving you or your family? Yes___ No___

Does your family currently have Child Protective Services involved? Yes___ No___

If yes—Please provide the following: Case Worker's Name:____

Telephone:__________________________________ State:_______ County:________________________

Other Agencies or Community Services involved?____

Medical/Psychological History

Who is providing client's history information? Client___ Other_______________________________________

Have you received or participated in Previous Counseling or Therapy? Yes___ No___

If yes—Who was your therapist?____

When did you begin therapy and for how long?____

Have you ever been Hospitalized for Psychological Concerns? Yes___ No___

If yes—Please briefly explain:

Have you received Substance Abuse Treatment? Yes___ No___

If yes—Where?____

When did you begin treatment and for how long?____

Any recent (30 days) Alcohol or Drug Use? Yes___ No___

If yes—Explain your pattern of use (how much/how often)____

Please describe the current complaint or problem as specifically as you can in your own words.

How long have you experienced this problem, or when did you first notice it?

Please check all words/phrases that express what you are experiencing and explain if possible.

___Substance abuse/dependence – If so, what is/are your substance of choice?	___Anxious/nervous/tense feelings
___Addiction (internet, pornography, shopping, exercise, gaming, gambling, etc)	___Panic attacks
___Depression/sad/down feelings	___Racing/scrambled thoughts
___High/Low energy level	___Nightmares/flashbacks
___Angry/irritable	___Hearing voices/hallucinations
___Loss of interest in activities	___Thoughts of running away
___Difficulty enjoying things	___Paranoid thoughts
___Crying spells	___Feelings of being cheated
___Decreased motivation	___Perfectionism
___Withdrawing from people/isolation	___Rituals of counting things/washing hands/checking locks/stove/etc/overly concerned about germs
___Mood swings	___Dissatisfaction with body image
___Change in weight/appetite	___Concerns about dieting
___Change in sleeping patterns	___Feelings of loss of control regarding eating
___Suicidal thoughts or plans – hurting yourself	___Binge eating/purging
___Self harm (cutting, burning, etc) – If so, date of last experience:	___Excessive exercise
___Homicidal thoughts or plans – hurting others	___Rules about eating
___Poor concentration/difficulty focusing	___Indecisiveness about career
___Feelings of hopelessness/worthlessness	___Job problems
___Feelings of shame/guilt	___Other – If so, describe:
___Feelings of inadequacy/low self-esteem	

Have you ever experienced any Significant Head Injuries? Yes___ No___

Current known Diagnosis:____

Current Major Health Concerns:____

Please explain any Allergies:

List current Medications (name, dosage, frequency):

Do you have a Primary Care Physician? Yes___ No___
If yes—Please provide the following: Physician's Name:_______________________________________
Practice Name:______________________________ Telephone:_____________________________

Any Abuse History? (physical, emotional, sexual) Yes___ No___

Please list any significant life events in the past 2 years? (moves, divorces, separations, deaths, trauma, etc)

List Personal and Social Resources and Strengths:____

What is your Spiritual preference? ________________ Would you like it included in therapy? Yes___ No___

What Goals/Expectations do you have for counseling therapy?

Is there any Additional Information that you believe is important for your therapist to know? Please explain.

Referral Source

Were you referred to our office? Yes___ No___
If yes—By whom?____
If no—How did you hear or learn about our office?____

Treatment Contract

"I agree to receive therapy at *Sunlight Counseling, LLC* and I acknowledge that I have received, read, understood, and agreed to the terms outlined in the **Professional Disclosure** of *Sunlight Counseling, LLC*. I also acknowledge that I have received or have been offered a copy of the **Notice of Privacy Practices** of *Sunlight Counseling, LLC* and that I understood the contents thereof."

Print Client's Name:____

Client's Signature:____ Date:___________________