Adult Intake Questionnaire

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All information is considered confidential and will not be released without your written consent

Name			DOB	Age
Address				
City		State		Zip
Home Phone	Cell Phone		Email	

What brings you to my office? Briefly describe your current situation.

How long has this been occurring? What do you believe caused it? What have you tried to change it?

Who lives in your home with you?

Marital Status: _____ Spouse/Partner/Significant Other's First Name:_____

How would you describe your current relationship?

How many times have you been divorced?_____ Widowed? _____

Please list all children and stepchildren (including those who do not live with you:

Name of Child	**Age**	**Sex**	**Do they live with you?**	**Describe your relationship** ***(How well do you get along?)***

Are you currently experiencing any difficulties in parenting your children? □ Yes □ No
If yes, please briefly describe:

Family Psychological History:

	Psychological/Emotional/Substance Use Issue **(depression, anxiety, ADHD, alcoholism, etc.)**	**Any Treatment**	**Ever Hospitalized for These Issues**
Mother			
Father			
Siblings			
Other			

In the space below, briefly describe your family of origin. Who were you raised by? Are your parents alive? If so, how old are they, how is their health, and how is your current relationship with them? If deceased, when did they die? If divorced/remarried, how old were you? As a child were you closer to your mother or father?

In a brief phrase, how would you describe your childhood environment?

Please describe any fearful/distressing/traumatic childhood experiences:

Please list all siblings, living and deceased, including name, age, where they live, and a description of your current relationship:

Please indicate by a check mark if the following have caused significant distress:

Ever	Last 2 weeks		Ever	Last 2 weeks	
☐	☐	School problems	☐	☐	Legal problems
☐	☐	Financial problems	☐	☐	Relationship problems
☐	☐	Childhood issues	☐	☐	Memory problems
☐	☐	Career problems	☐	☐	Sexual concerns
☐	☐	Sadness/Depression	☐	☐	Don't need as much sleep
☐	☐	Lack of enjoyment in activities	☐	☐	Racing thoughts
☐	☐	Difficulty starting anything	☐	☐	Short attention span
☐	☐	Change in appetite	☐	☐	Talking a lot (more than normal)
☐	☐	Weight loss or gain	☐	☐	Feeling on top of the world
☐	☐	Sleep problems (too much / not enough)	☐	☐	Irritability
☐	☐	Fatigue / feeling tired	☐	☐	Worry/Anxiety
☐	☐	Feelings of worthlessness	☐	☐	Jittery / jumpy / restless
☐	☐	Guilt	☐	☐	Increased muscle tension
☐	☐	Difficulty focusing / Easily distracted	☐	☐	Heart racing / chest pain
☐	☐	Loss of interest in others	☐	☐	Trembling / shaking
☐	☐	Difficulties making decisions	☐	☐	Smothering / shortness of breath
☐	☐	Thoughts of hurting self	☐	☐	Choking sensation
☐	☐	Suicidal thoughts	☐	☐	Nausea
☐	☐	Urge to hurt someone else	☐	☐	Dizzy / faint / lightheaded
☐	☐	Hopelessness	☐	☐	Feeling detached from self / feelings of unreality
☐	☐	Eating out of control	☐	☐	Fear of losing control or going crazy
☐	☐	Recurring thoughts that can't be controlled	☐	☐	Fear of dying
☐	☐	Flashbacks (re-experiencing a past event)	☐	☐	Numbness or tingling
☐	☐	Traumatic event	☐	☐	Chills or hot flushes
☐	☐	Recent loss/grief	☐	☐	Avoiding public places
☐	☐	Concern about weight	☐	☐	Concern others are judging / watching you
☐	☐	See or hear things others don't	☐	☐	Unusual thoughts or ideas
☐	☐	Intentionally skipping meals	☐	☐	Urges to repeat behaviors

Have you or a family member ever been diagnosed with the following?

Diagnosis	Self	Relative	Diagnosis	Self	Relative
Speech Problems	☐	☐	Premature birth	☐	☐
Vision Problems	☐	☐	Lung/Respiratory problems	☐	☐
Hearing Problems	☐	☐	Frequent ear infections	☐	☐
Learning Disability	☐	☐	Headaches	☐	☐
Developmental Delay	☐	☐	Chronic Pain	☐	☐
Mental Retardation	☐	☐	Fibromyalgia	☐	☐
Autism	☐	☐	Allergies	☐	☐
Attention Problem	☐	☐	Diabetes	☐	☐
Hyperactivity	☐	☐	High blood pressure	☐	☐
Substance Abuse	☐	☐	High cholesterol	☐	☐
Alcoholism	☐	☐	Heart disease	☐	☐
Legal Problems	☐	☐	Cancer	☐	☐
Victim of domestic violence	☐	☐	HIV/AIDS	☐	☐
Sexual abuse or rape victim	☐	☐	Stroke or TIA	☐	☐
Physical abuse victim	☐	☐	Seizures/Epilepsy	☐	☐
Depression	☐	☐	Perpetrator of abuse	☐	☐
Bipolar Disorder (manic-depression)	☐	☐	Memory problems	☐	☐
Anxiety	☐	☐	Dementia/Alzheimer's	☐	☐
Eating Disorder	☐	☐	Hazardous substance exposure	☐	☐
Personality Disorder	☐	☐	Excessive exposure to lead	☐	☐
Schizophrenia	☐	☐	Injury requiring hospitalization	☐	☐
Suicide attempt	☐	☐	Head injury	☐	☐
Other psychiatric illness	☐	☐	Surgeries	☐	☐

Current health care provider:_____ Phone number:_____

Date of last visit:_____ Reason for last visit:_____

Please list all current medications (both prescription and over-the-counter):

Medication	Prescriber	For	Dosage	Side effects

Please indicate your usage of the following substances:

Substance	Current	Past	Average Usage
Caffeine			
Tobacco			
Alcohol			
Marijuana			
Misuse of Prescription Drugs			
Inhalants			
Hallucinogens (LSD/Ecstasy/PCP/mushrooms)			
Opiates (Heroin/Morphine)			
Steroids (misuse only)			
Stimulants (Meth/Crack/Cocaine/Crank)			

In the past 12 months, has your substance use repeatedly caused or contributed to:

Interference with home, work, or school obligations? ☐ Yes ☐ No
Risk of bodily harm (drinking and driving, operating machinery, swimming) ☐ Yes ☐ No
Run-ins with the law (arrests or other legal problems) ☐ Yes ☐ No
Relationship trouble (family or friends) ☐ Yes ☐ No

In the past 12 months have you:

Needed to use substances a lot more to get the same effect ☐ Yes ☐ No
Shown signs of withdrawal such as tremors, sweating, nausea, or insomnia when trying to quit or cut down ☐ Yes ☐ No
Not been able to stick to limits you set for yourself for substances ☐ Yes ☐ No
Not been able to cut down or stop using substances ☐ Yes ☐ No
Spent a lot of time using, anticipating using, or recovering from using ☐ Yes ☐ No
Spent less time on other activities that had been important in the past ☐ Yes ☐ No
Kept using substances despite problems ☐ Yes ☐ No

Have you ever been treated for substance use problems? ☐ Yes ☐ No

Dates	Provider	Focus of Treatment (Substance)

Please list previous psychotherapy, counseling, or other treatment for personal or marital problems:

Dates	Provider	Focus of Treatment

Have you ever been hospitalized for psychiatric reasons? □ Yes □ No

If yes, briefly describe when and for what reason:_____

_____

Have you ever thought of taking your own life? ☐ Yes ☐ No
Have you ever attempted to hurt yourself? ☐ Yes ☐ No
Have you ever attempted to end your own life? ☐ Yes ☐ No
If yes, how many times, when, and by what method?

Are you currently in school?_____ If so, where?_____
What is your highest level of education (last grade or degree completed)?_____
When did you graduate, or if you are in school, when will you graduate?_____
What type of student were/are you? What kind of grades did you get?

Did any of the following occur during your childhood?

	✓		✓
Difficulty making friends	☐	Participated in extracurricular activities	☐
Teased/bullied by others	☐	Difficulty concentrating in class	☐
Suspended or expelled	☐	Tutoring	☐
Getting into physical fights	☐	Attended special program	☐
Repeated a grade/held back	☐	Failed a class	☐
Truancy/skipped class frequently	☐	Changed schools due to a move	☐
Refused to go to school	☐	Removed from home due to abuse/neglect	☐
Skipped a grade	☐	Other:	☐

Please list your work history, beginning with your current job and working backward:

Employer	Position Held	Dates	Reason Left

Were you ever in the military? ☐Yes ☐No
If yes: please list your branch, dates enlisted, discharge rank, discharge type, and any injuries you sustained while in the service:

Have you ever been arrested? ☐Yes ☐No
If yes, please list (with dates) all arrests, charges, convictions, and sentences you may have received:

Are you currently a party to any kind of lawsuit? ☐Yes ☐No
If yes, please elaborate:

What are your current hobbies, interests, or ways you use your free time?

Have you changed your level of involvement in any of these activities recently? ☐Yes ☐No

Do you exercise regularly? ☐Yes ☐No If yes, what do you do?_____

Please rate your current level of distress on a scale of 1 to 10 (10 being highest):_____

How do you cope with stressful situations?

What are some of your strengths?

Who is in your social support system, and how strong do you feel that support system is?

What do you hope to get out of therapy? What goals do you have?
1._____
2._____
3._____
4._____
5._____

How were you referred to my office?

Is there anything else that is important for me to know that is not on this form? If so, please write about it here:

Signed: Date: