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Adult Intake Questionnaire

Client Name: ____
(Last) (First) (Middle Initial)

Client's Birth Date: ______ /______ /______ **Age:** _____________ **Gender:** _____________________

Ethnicity: _______________________________ **Preferred Language:** ________________________

Sexual Orientation: ________________________

Highest Educational level completed: _______ **Occupation:** ________________________________

MARITAL STATUS:

☐ **Never Married** ☐ **Domestic Partnership** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Do you have any children? ☐ **Yes** ☐ **No** **If yes, how many?** _____________________________

Please list names/ages of any children: ____

____

Client's Address: ____
(Street and Number)

____
(City) (State) (Zip)

Home Phone: (**)** _________________________ **May I leave a message?** ☐ **Yes** ☐ **No**

Cell/Other Phone: (**)** _______________________ **May I leave a message?** ☐ **Yes** ☐ **No**

Emergency contact: ____
Name/Relation

Address: ____
(Street and Number)

____
(City) (State) (Zip)

Contact Phone: (**)** _________________________ **May we leave a message?** ☐ **Yes** ☐ **No**

Referred by (if any): ____

FINANCIAL INFORMATION:

How do you intend to pay for treatment? (cash, check, charge, insurance) ____________________

If planning to use health insurance:

Name of insurance company ____

Policy/ID number ______________________________ **Group number** _________________________

Address: ____
(Street and Number)

____
(City) (State) (Zip)

Contact Phone: ( ) ____

Name of Insured (if other than client): ____

Policy/ID# __________________________________ **Group number** ____________________________

Insured's Birth Date: ___________________________

Insured's Address: ____
(Street and Number)

____
(City) (State) (Zip)

Insured's Phone Number: __________________________ **Home Mobile Work**

Insured's Employer: ____

Client's relationship to Insured: ____

AREAS OF CONCERN:

Current symptoms/behaviors/issues/concerns for which you are seeking treatment? ___________

____

____

____

How long have you experienced the current symptoms/behaviors/issues/concerns and how do they impair your functioning at home, school, work, in relationships, in the community, etc.?

____

____

____

What have you done to address the current symptoms/behaviors/issues/concerns?

____

Do you have any specific goals with regard to your treatment? What would you like to accomplish out of your time in therapy?

____

____

Do you have any particular concerns/fears with regard to treatment? ________________________

____

PSYCHOLOGICAL HISTORY:

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ☐ Yes ☐ No

If yes, what was the focus of treatment? ____

When and for how long? ____

Name of mental health service provider: ____

Address: ____
(Street and Number)

____
(City) (State) (Zip)

Contact Phone: (   ) ____

Have you ever been subjected to one or more psychological tests? ☐ Yes ☐ No

If yes, by whom? ____

Name of person(s) administered psychological tests: ____________________________________

Address: ____
(Street and Number)

____
(City) (State) (Zip)

Contact Phone: (   ) ____

Have you ever been hospitalized for mental or emotional problems? ☐ Yes ☐ No

If yes, when and for how long? ____

Why were you hospitalized? ____

Name of treating doctor, therapist, other provider: ____________________________________

Address: ____
(Street and Number)

____
(City) (State) (Zip)

Contact Phone: (   ) ____

*Please note: Authorization for release of confidential information will be needed so that any former mental health service providers may be contacted.

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

Have you ever attempted suicide? ☐ Yes ☐ No

If yes, when/how? ____

____

Describe the circumstances that led to that attempt: ___________________________________

____

____

Are you currently having any suicidal thoughts? ☐ Yes ☐ No

If yes, please describe ____

____

____

Please describe your childhood: ____

____

Have you ever been subjected to verbal, physical, emotional, sexual abuse? ☐ Yes ☐ No

If yes, please describe: ____

____

____

Have you ever been a victim of a violent crime? ☐ Yes ☐ No

If yes, please describe: ____

____

Medical History:

Name of Primary Care Physician: ____

Address: ____

____

Phone: ____

Are you currently experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? ☐ Yes ☐ No

If yes, please describe: ____

____

How would you rate your current physical health today? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Date of your last physical examination: ______________________________

Allergies/allergic conditions: ______________________________

Accidents/Surgeries/Hospitalizations: ______________________________

Please list any specific health problems you are currently experiencing:

____

Are you currently taking any prescription medication? ☐ Yes ☐ No

Please list medication you are currently taking: ______________________________

____

Medications prescribed by whom? ______________________________

How long have you been on the medications? ______________________________

Have you ever taken any medications for a mental or emotional condition? ☐ Yes ☐ No

If yes, when and for how long? ______________________________

Have you ever been diagnosed with a serious/chronic illness? ☐ Yes ☐ No

If yes, please describe: ______________________________

Do you have any medical conditions that may affect your mental health treatment? ☐ Yes ☐ No

If yes, please describe: ______________________________

____

Do you smoke? ☐ Yes ☐ No

If yes, how much? ______________________________ For how long? ______________________________

Do you drink alcohol? ☐ Yes ☐ No

Do you drink alcohol more than once a week? ☐ Yes ☐ No

If yes, on average, how much alcohol do you consume in a week?______________________________

Do you currently use/abuse any illegal/recreational/prescription drugs? ☐ Yes ☐ No

How often do you engage in illegal/recreational/prescription drug use/abuse?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Don't engage

Please list illegal/recreational/prescription drugs used/abused: ______________________________

____

Have you ever used/abused any illegal/recreational/prescription drugs? ☐ **Yes** ☐ **No**

If yes, what did you use/how often did you use it/when did you last use it? ____________________

____

How would you rate your current sleeping habits? (please circle)

Poor **Unsatisfactory** **Satisfactory** **Good** **Very good**

Please list any specific sleep problems you are currently experiencing:

____

How many times per week do you generally exercise? _____________________________________

What types of exercise to you participate in: ____

Please list any difficulties you experience with your appetite or eating patterns:

____

Are you currently experiencing overwhelming sadness, grief or depression? ☐ **Yes** ☐ **No**

If yes, for approximately how long? ____

Are you currently experiencing anxiety, panic attacks or have any phobias? ☐ **Yes** ☐ **No**

If yes, when did you begin experiencing this? ____

Are you currently experiencing any chronic pain? ☐ **Yes** ☐ **No**

If yes, please describe ____

Are you currently in a romantic relationship? ☐ **Yes** ☐ **No**

If yes, for how long? ____

On a scale of 1-10 (1 being the lowest level of satisfaction, 10 being the highest level of satisfaction), how would you rate your current relationship? _______________________________

What significant life changes or stressful events have you experienced recently:

____

____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (mother, father, sister, brother, grandmother, grandfather, aunt, uncle, etc.):

Alcohol/Substance Abuse: yes/no ____

Anxiety: yes/no ____

Depression: yes/no ____

Bipolar Disorder: yes/no ____

Eating Disorder: yes/no ____

Obesity: yes/no ____

Obsessive Compulsive Behavior: yes/no _______________________________________

Schizophrenia: yes/no ____

Suicide Attempts: yes/no ____

Domestic Violence: yes/no ____

<u>CRIMINAL HISTORY</u>:

Have you ever been incarcerated? ☐ **Yes** ☐ **No**

If yes, please provide details: ____

____

Do you have any pending charges against you? ☐ **Yes** ☐ **No**

If yes, please provide details: ____

____

Are counseling services court ordered? ☐ **Yes** ☐ **No**

If yes, please provide details: ____

____

<u>CPS HISTORY</u>:

Have you ever been accused of child abuse or neglect? ☐ **Yes** ☐ **No**

If yes, please provide details: ____

____

Have you had or do you currently have an open CPS case? ☐ **Yes** ☐ **No**

If yes, please provide details: ____

____

Are counseling services court ordered? ☐ **Yes** ☐ **No**

If yes, please provide details: ____

____

<u>EMPLOYMENT INFORMATION</u>:

Are you currently employed? ☐ **Yes** ☐ **No**

If yes, what is your current employment situation: ____

Do you enjoy your work? ☐ **Yes** ☐ **No**

Is there anything stressful about your current work? ☐ **Yes** ☐ **No**

Please describe: ____

<u>SPIRITUAL BELIEFS</u>:

Do you consider yourself to be spiritual or religious? ☐ **Yes** ☐ **No**

If yes, describe your faith or belief (i.e., Christian, Muslim, Buddhism, etc.): ___________________

Religious Affiliation/Denomination (i.e., Baptist, Methodist, Catholic, etc.): ____________________

<u>ADDITIONAL INFORMATION</u>:

Please describe your interests/hobbies: ____

Are you now or have you ever been involved in a lawsuit? ☐**No** ☐ **Yes**

If yes, please describe. ____

____

What do you consider to be some of your strengths?

____

____

What do you consider to be some of your weakness? ___________________________________

____

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested:

____