INTAKE QUESTIONNAIRE – ADULT

Your response to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.

Name of person completing form: _____ Date: _____

IDENTIFYING INFORMATION (for individual receiving services)

Name: _____ Date of Birth: _____

Address: _____ Sex: _____

_____ Marital Status: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Social Security Number: _____

Who referred you to [organization's name]? _____

Disability:
Do you have a disability? ☐ Yes ☐ No If yes, please specify: _____
If you have a disability, does the office accommodate your needs? ☐ Yes ☐ No
If no, please explain: _____

If you feel that the therapist should be aware of any special treatment considerations due to gender, age, sexual orientation or cultural, religious, national, racial or ethnic identity, please explain below:

_____

_____

_____

PRESENTING PROBLEM (current situation and history)

1. Please check any of the reasons listed below which led you to seek treatment, circling up to the 3 **most important**:

__ Depression or anxiety
__ Worry about drinking or drug use
__ Communication problems
__ Desire to improve sexual relations
__ Parent/child conflict
__ Sexual orientation questions
__ Problematic or too much anger
__ Social isolation or other social challenges
__ Trouble controlling impulses
__ Abuse (physical/sexual/emotional/verbal)
__ Trauma other than abuse (natural disaster, accident, crime witness, etc.)
__ Thinking of harming self or others
__ Learning/memory problems
__ Difficulty with loss or death
__ Want relationship to be better
__ Divorce counseling
__ Individual counseling
__ Pre-marital counseling
__ Family counseling
__ Couples counseling
__ Partner/family member wanted me to come
__ Other: _____

2. Regarding the **most important** reason that brings you here, please rate the following:

Reason 1. _____

How often does issue happen?	How often does issue happen?	How does it affect your functioning?
__ Happens rarely	__ Happens rarely	__ I can do all the things I need and want to do
__ Happens 1-2 times a week	__ Happens 1-2 times a week	__ I struggle a bit but am able to do all I need and want to do
__ Happens 3-5 times a week	__ Happens 3-5 times a week	__ I can only do some of the things I need and want to do
__ Happens daily	__ Happens daily	__ I can barely do the things I need to do
__ Happens several times a day	__ Happens several times a day	__ I am unable to work or care for myself

Reason 2.

Reason 3.

3. How long have you had this/these problem(s)? _____

4. Have you received treatment for this problem or any other problem in the past? ☐ Yes ☐ No

If yes when, where and with whom? _____

_____

FAMILY HISTORY

1. Have any of your family members experienced any type of mental health concerns? ☐ Yes ☐ No

If yes, please explain: _____

_____

2. Do you or another family member have a history of alcohol or drug problem? ☐ Yes ☐ No

If yes, please explain: _____

_____

3. Please describe your current alcohol consumption: _____

_____

4. Was there any type of abuse (physical, sexual, domestic or emotional) in your family or home?

☐ Yes ☐ No If yes, please describe the circumstances: _____

_____

5. Have you or any other family member experienced any type of abuse? ☐ Yes ☐ No

If yes, please explain: _____

LEGAL HISTORY

Please describe any involvement you have had with the legal system (arrests, convictions, probation, parole):

_____

_____

CURRENT FAMILY INFORMATION

1. Please provide the following information:

Name (First and Last)	**Date of Birth**	**Lives with You?**
Spouse/Significant Other:		Yes No
Children: _____		Yes No
_____		Yes No
_____		Yes No
_____		Yes No
Others Living in Household:		

2. Highest educational level achieved: _____

3. Military service: ☐ Yes ☐ No

4. Occupation: _____

5. Current employer: _____

MEDICAL HISTORY

1. Primary Care physician/pediatrician: _____

2. Please check the appropriate box if you have experienced any of these problems:

- ☐ Eye disease, injury, poor vision
- ☐ Ear disease, injury, poor hearing
- ☐ Nose, sinus, mouth, throat problems
- ☐ Head injury
- ☐ Convulsions or seizures
- ☐ Memory problems
- ☐ Extreme tiredness or weakness
- ☐ Thyroid disease or goiter
- ☐ Skin disease
- ☐ Heart disease
- ☐ Back, arm, leg or joint problems
- ☐ Blood disease
- ☐ Stomach problems
- ☐ Premenstrual Syndrome (PMS)
- ☐ Eating disorder
- ☐ Liver, gallbladder disease
- ☐ Chest pain or angina pectoris
- ☐ Cancer
- ☐ Bowel problems
- ☐ Hemorrhoids, rectal bleeding
- ☐ Loss of consciousness
- ☐ Frequent or severe headaches
- ☐ Sleep disturbances
- ☐ Neck stiffness, pain, swelling
- ☐ Marked weight changes
- ☐ Circulatory problems
- ☐ Allergies or asthma
- ☐ Diabetes
- ☐ Encephalitis
- ☐ Meningitis
- ☐ Pregnancy not carried to term/stillbirths
- ☐ High blood pressure
- ☐ Other _____

Please explain anything checked above: _____

3. Please provide information about medication(s), prescription or over-the-counter, which you take regularly:

Medication	Dosage/Frequency	Prescribing Physician	For what condition?

4. Please list significant hospitalizations, operations, injuries (including broken bones): _____

_____

GOALS

1. What are your strengths? _____

_____

2. What are your limitations? _____

_____

3. What goals would you like to see reached as a result of your involvement with *C.A. Counseling & Consultants?*

_____

_____

_____

_____

4. How will you know when these goals have been reached?

_____

_____

_____

_____

5. Who would you say is your biggest support system?

_____

_____

_____

_____

6. If there seems to be concerns with you and your partner, how you would you best describe the concerns between the two of you?

_____

_____

_____

_____

7. How would your partner describe the concerns between the two of you?

_____

_____

_____

_____

8. What is it you want that you don't have within your life?

_____

_____

_____

_____

9. What is it you have that you no longer want within your life?

_____

_____

_____

_____

Is there any other information that would useful for your therapist to know?

_____

_____

_____

_____

_____

_____

_____

_____

THERAPIST REVIEW

Signature: _____ Date: _____