Adult Intake Questionnaire

Name and age_____

Please indicate the means by which you prefer to be contacted. You may check more than one:
Phone: _____ Text: ____ E-mail: _____ Regular Mail: ____
Date of Birth: _____ Age: _____
Emergency Contact Information: Name: _____ Relationship: _____
Phone number: _____
Gender:
Woman: ___ Man: ___ Transgender: ___ Gender Nonconforming: _____ Other: _____
Goals of Treatment:
What compelled you to seek therapy at this time?
_____
_____
_____
Describe your current concerns, issues, or problems that you hope to resolve:
_____
_____
_____
What do you hope to gain from therapy?
_____
_____
_____
Relationship Status (Please check all that apply):
Are you presently married or involved in a relationship? Yes_____ No_____
If you answered yes, how would you describe your current level of satisfaction with the relationship?
_____
Have you married previously? If yes, when? _____
Name of the individual whom you identify as your significant other:
_____
If you are married, or in a relationship, rate your level of contentment/happiness/satisfaction in the relationship on a scale of 1 to 10 (Number 1 indicates a sense of being very or extremely happy and the number 10 indicates a sense of being extremely unhappy). Briefly explain the rating you give in the space provided:
_____
Current Employment Status (Please check all that apply):
Working Full-Time: _____ Working Part-Time: _____ Retired: _____
On medical leave: _____ Unemployed and looking for work: _____
Not employed due to other reasons ____ Full-Time Student: _____ Part-Time Student:___
Military History:
Currently on active duty: _____ Served in Military (please circle length of time served) for: _____ number of weeks, months, or years. Never served in the military: _____

If you have served in the military were you ever deployed, yes or no? Yes: _____ No: ____.
If yes, please describe your deployment experience and any incidence or issues that arose for you during or after your deployment:

_____
_____
_____

Legal History:

Have you been ordered by the court to participate in this therapy, yes or no?
Yes: ____ No: ____If yes, you may be required to supply supporting documentation such as a copy of the court order.
Are you currently involved in any kind of litigation or legal dispute, yes or no?
Yes: _____ No: _____ If yes, please explain (i.e., custody dispute, dissolution proceedings, etc.):

_____
_____
_____

Referral Information:

Were you referred? Yes: _____ No: _____ If referred, by whom?

_____

Previous Mental Health Treatment History:

Have you participated in therapy? Yes: _____ No: ____ If YES, please complete the information below:

Name: _____ Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):_____
Phone Number: _____ Street Address: _____ City: _____ State: _____
Dates of treatment: _____
Focus of treatment: _____

Name: _____Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):_____
Phone Number: _____ Street Address: _____
City: _____ State: _____ Dates of treatment: _____
Focus of treatment: _____

Have you ever been hospitalized because of a mental health disorder?
Yes: _____ No: _____. If you indicated that you have been hospitalized for a mental health disorder, please complete the following information:

Reason for hospitalization:

_____
Was hospitalization voluntary or involuntary? Please check: Voluntary: _____ OR Involuntary: _____
How long was your hospitalization?

_____
Where were you hospitalized?

_____
_____
Course of treatment during hospitalization:

_____

_____
_____

Current Mental Health Treatment:

Are you currently participating in therapy or counseling? Yes: ____ No: _____

If YES, please complete the following information:

Name of Current Provider: _____

Type of provider: _____

Phone Number: _____ Street Address: _____ City: _____

State: _____ Dates of Treatment: _____

Focus of Treatment: _____

******If you are currently receiving therapeutic services from another psychotherapist, to avoid a duplication of services, it may be necessary for me to contact your current psychotherapist to coordinate care. You may be required to sign and *"Authorization for Release of Confidential Information"* form which will be provided to you and maintained as part of your clinical record **a**long with a copy of this patient intake form.***** Please Initial: _____

Are you prescribed any psychiatric medication(s), yes or no? Yes _____ No_____.

If yes, please list the type of medication, prescribing physician, the specific medication you have been prescribed, the dosage, and any side effects in the space below.

For example: *"Antidepressant (type), Zoloft (specific medication), 50mg once daily (dose), Insomnia (side effect)."* _____

_____

_____ _____

_____

Have you participated in any psychological assessments or tests yes, or no? Yes ____ No _____.

Please describe.

_____

_____

_____

Medical Treatment Information:

Are you currently seeking treatment for a serious or chronic non-psychiatric medical condition, yes or no? Yes: _____ No: _____. If you currently have a medical condition, please provide the following information:

Current medical condition: _____ How long have you had the condition? _____ Is it a medically treatable condition, yes or no? Yes: _____ No: _____ If, it is not a medically treatable condition (i.e., palliative care), please describe:

_____

_____

_____

Trauma History :

Have you been – or are you currently being – emotionally, physically, or sexually abused?

Yes _____ No _____ Prefer not to answer _____.

If you checked "Yes," you may use the space below to describe the underlying circumstances:

_____

_____

_____

How would you describe your childhood?

Outstanding Normal Chaotic Witnessed Abuse
Experienced abuse

Please list any problems related to your birth (including premature):

_____

Please list any significant childhood illnesses.

_____

Did you have a 504 Plan/Individualized Education Program (IEP)? If yes, please describe.

_____

How would you describe yourself as a child/adolescent? Circle all that apply.

Normal Interactions	Promiscuous behavior	Easily distracted	Chronic lying	Easily distracted
Dominated others	Bullied	Difficulty maintaining relationships	Lonely	Violent temper
People pleaser	Shy	Struggle with authority	Theft	Isolated self

Mental Health/Risk Assessment:

Are you currently suicidal? Yes No

Have you ever felt suicidal? Yes No

If yes, explain.

_____

_____

Alcohol/Substance Use History:

Family Alcohol Abuse History: To the best of your knowledge, please indicate which of the following family member(s) struggles or struggled with alcohol/substance abuse or addiction:

Father: _____ Mother: ____ Grandparent(s): ____ Sibling(s): _____

Stepparent(s): _____ Uncle(s)/Aunt(s): ____ Spouse/Significant Other: _____ Children: _____

Please use the following scale to fill in the blanks:

0=never 1= experimental 2=occasional 3-Monthly 4=Weekly 5=Daily 6=Heavily in the past

___ Coffee ___Tea ___ Energy Drinks ___ Tobacco ___ Prescription Pain Med.

___Marijuana ___ Inhalants ___Steroids ___Alcohol ___ Sleep Aids

___Cocaine ___Heroin ___Crack ___Crystal ___Other

Symptoms Checklist

Please check (X) each symptom that currently applies and indicate frequency.

	Currently	Daily(D), Weekly(W) Monthly(M)?	Experienced in the past?		Currently	Daily(D), Weekly(W) Monthly(M)?	Experienced in the past?
Depressed Mood				Frequent Headaches			
Weight loss/gain				Loss of motivation			
Difficulty sleeping				Fatigue/low energy			
Poor concentration				Increased anger			
Mood swings				Anxiousness			
Panic attacks				Obsessive thoughts			
Binging				Paranoia			
Delusions				Elevated mood			
Increased Impulsivity				Worthlessness			
Hopelessness				Physical Trauma			
Dissociative States				Chronic Pain			
Sexual Trauma				Flashbacks			
Social Isolation				Self-harm			
Increased Sleep				Guilt			
Irritability				Low self esteem			
Increased emotional sensitivity				Increased aggression			
Unreasonable Fears				Guilt			
Purging				Substance abuse			
Hallucinations				Nightmares			
Increased/Decreased Sex Drive				Loss/increase in appetite			
Shame				Excessive worry			

Please try to name 3 goals you would like to accomplish through therapy:

1. _____
2. _____
3. _____

Anything else I need to know about you?

_____

_____

_____

_____