



ADULT INTAKE QUESTIONNAIRE

Please answer all information as completely as possible. Please ask for assistance if needed.

Today's Date: _____ **Your Full Name:** _____

Last, First, M.I.

Date of Birth: _____ Age: _____ Preferred Pronouns: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Present Employer: _____ How long? _____

Your Emergency Contact Name and Phone: _____

If a student, grade in school: _____ Name of School: _____

Dating/ Marital Status (Name and for how long):

____ Dating: _____

____ Married: _____

____ Separated/Divorced: _____

____ Widowed: _____

Any History of alcohol/drug/substance abuse? _____ (if yes, explain) _____

Any History of family violence? _____ (if yes, explain) _____

Any History of criminal activity? _____ (if yes, explain) _____

List any present medical problems, and, or current medications: _____

Doctor's Name and Phone Number: _____

Have you had previous counseling, or psychiatric care? _____ If yes, please indicate when and with whom: _____

What did you find helpful? _____

Psychiatrist's Name and Phone, if applicable: _____

What are your 2-3 immediate counseling goals? _____

What are the main stressors you have had in the past year? (ex. Job loss, divorce, marriage, birth of a child, death in family, surgery, move, etc.) _____

CLIENT'S HISTORY and EXPERIENCES: Please mark 'P' to indicate symptoms of the PAST and mark 'N' for any symptoms that are a major concern to you NOW and rate them as a 1-10 in severity.

___ Suicidal thoughts	___ Suicide attempts	___ Crying spells
___ Appetite change	___ Weight loss/ weight gain	___ Self-harm
___ Trouble sleeping	___ Difficulty having fun	___ Lack of energy/ Fatigue
___ Mood swings	___ Very angry	___ Feeling down/ Depressed
___ Poor grooming	___ Social isolation	___ Sleeping too much
___ Self-harm	___ Lack of motivation	___ Lack of enjoyment
___ Difficulty concentrating	___ Feelings of hopelessness	___ Loneliness
___ Feeling more irritable	___ Decreased interest in hobbies	___ Aggressive behavior
___ Heart palpitations	___ Anxious, worrisome thoughts	___ Feeling "on top of the world"
___ Risky behavior	___ Phobias/ specific fear(s)	___ Panic attacks
___ Racing thoughts	___ Unable to control thoughts	___ Rapid, pressured speech
___ Oppositional behavior	___ Troubles at home	___ Domestic violence
___ Child abuse	___ Emotional abuse/ trauma	___ Physical abuse/ trauma
___ Sexual abuse/ trauma	___ Bullying	___ Difficulties with peers
___ Procrastination	___ Sensitivity to textures, light, sounds	___ Immature for age
___ Able to 'hyper-focus' when interested or on deadline	___ Unorganized, hard to get started or to complete tasks	___ Poor choices in friends
___ Easily bored, seek excitement or entertainment	___ Extra sensitive to perceived slights or criticism	___ Compulsive sexual behavior
___ Mood swings from very up to very down or agitated	___ Engages in risky or excessive behaviors (sex, shopping, gambling, etc.)	___ Hard time shifting out of a mood, may persist for hours or days
___ Socially awkward		
___ Often feel guilty, to blame	___ Desires, acts of self-harm	___ Desires, intent to end your life
___ Intense anger	___ Desires, intent to harm others	___ Desire to be in control
___ Feelings of panic, dread	___ Intrusive, unwanted thoughts	___ Avoidance of certain smells, things, places, situations, etc.
___ Worry about germs, illness, or contamination	___ Need for things to be ordered, tidy, or just so, in order to feel okay	___ Repetitive acts or behaviors to ease unwanted thoughts
___ Drug use/ alcohol use	___ Career problems	___ Legal problems
___ Excessive guilt	___ Stubborn, resistant	___ Hold grudges when upset
___ Feel superior to others	___ Hear voices when no one around	___ Suspicious of other people
___ Passive-aggressive	___ Feel that others are out to get you	___ Want/ seek admiration
___ Want/ seek pity	___ Believe you have a unique ability	___ Want/ seek to be rescued

____ Violent or aggressive at work or home	____ Feeling that things happen around you, as if you're watching a movie	____ Feeling detached from reality
____ Experience blackouts or loss of time	____ Hearing, seeing, or smelling things that others don't	____ You receive messages from others thru TV, radio, computer, etc.

CLIENT's HEALTH HISTORY AND SOCIAL FACTORS:

Please describe your weekly exercise habits and if you have any other goals for that:

What nutritional supplements do you take? _____

How much sleep do you usually get per night? _____ If applicable, what do you think might contribute to your sleep difficulties? _____

Have you ever had any major illnesses, traumatic injuries, or major surgeries? If yes, please list what and when. _____

Have you ever been hospitalized? If yes, please list for what and when. _____

Do you have any chronic illnesses? If yes, please list what and when diagnosed.

What are your hobbies and what social interactions/ activities do you enjoy on a regular basis?

(Check the number that best applies)

How would you rate Your Support System (such as friends, relatives, school or religious organization) ?

Hardly any support ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 Considerable support

Who is in your support network? Names and relation to you:

What are 2-3 things that give your life meaning and purpose? _____
