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Adult Intake Questionnaire

(Please answer the following questions to the best of your knowledge.)

Client Information:

Name:_____Date:_____

Last First Middle

Date of Birth:_____ Home Address:_____

_____

Phone Numbers: (home)_____(cell)_____

Marital Status: Single_____ Married_____ Other_____ Gender: Male_____ Female_____

Emergency Contact Name, Address, & Phone Number:_____

_____

Primary Care Physician:_____ Off. #:_____

Referred By:_____

Insurance Information:

Insurance Company(s) Name & Address:_____

Name of Insured:_____ Insured's ID Number:_____

Group #:_____Customer Service Phone #:_____

Employer:_____

Client Name:_____

Please describe why you are seeking services at this time:_____

How long have you experienced this issue(s)?_____

What things have you tried to resolve the issue(s)?_____

Please describe your present living situation (lives alone, w/spouse, parents . . .) and your response to it:_____

Has there been domestic violence among family members, past or present? If yes, please describe:_____

Who gives you emotional support (i.e., friends, family, social/religious/community organizations?)_____

Have you experienced any traumatic events in the past? (i.e., significant injuries, major illnesses, deaths, divorces, moves, other losses, etc.) If yes, please describe:_____

Client Name:_____

Have you experienced emotional, physical, or sexual abuse? If yes, please provide information regarding the type(s) of abuse and what has been done about it:_____

Please list any significant life events (anything which may be important to you.):_____

What religion or philosophy/beliefs do you acknowledge?_____

What is the level of importance of your religion or beliefs in your life?_____

What do you do for fun, relaxation, and enjoyment?_____

What is the level of education you have achieved? Please describe any difficulties experienced or any learning disabilities?_____

Are you presently satisfied with work/school? If not, please explain (please note current school attended, if applicable):_____

Do you presently use alcohol or any other substance? If so, how much and how often?_____

At what age did you begin us use substances, if so, and were there any noted consequences such as blackouts, job losses, arrests?_____

Client Name:_____

Is there a biological family history of alcohol/drug problems?_____

Do you have any history of arrests or violence toward others or to animals? If yes, please describe:_____

Are you currently on probation? If yes, what is the expected date of completion?_____

How has your legal history (if any) impacted your life/family/work/social interactions?_____

Do you have any known medical conditions (i.e., diabetes, high blood pressure, allergies, etc.) or a past head injury? If yes, please describe:_____

Please list any current medications taken for medical conditions:_____

Have you experienced nightmares or sleeping difficulty? If yes, please describe: _____

Have you experienced difficulty with food (eating too much, too little, etc.)? If yes, please describe:_____

Do you have a history of previous psychiatric inpatient admission? If yes, please describe:_____

Do you have a history of previous outpatient therapies? If yes, when:_____

Client Name:_____

Do you presently have suicidal thoughts or have a history of references to or attempts at suicide? If yes, please describe:_____

Do you have a history of a self-harm (i.e., cutting, burning self)? If yes, please describe:_____

Please list any psychiatric medications prescribed and taken (past & present) and the results:_____

Please provide a brief description of your family psychiatric or emotional history (if known) and any other additional information you feel is relevant to your needs or treatment (it is not required that you fill the entire space provided):_____