VIRGINIA C. RENFROE,

MA, LPC

Texas License - 19759

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**832.725.7694**

141 E. Mercer St., Suite C, Dripping Springs, TX 78620

**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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1 of 5

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:

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?

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:

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):\_