Name Initials: _______ Date: ___________________

ADULT INTAKE QUESTIONNAIRE

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name: _______________________________________ **Birth Date:** ____________ **Age:** _________

Gender: _______________________________________ **Marital Status:** _______________________

Spouse Name (if applies): _______________________________ **Spouse occupation:** _____________

Address: ___________________________________ **City** ___________ **State** _______ **ZIP** ________

Cell phone: _________________________________ **Email:** ___________________________________

In case of emergency, contact: ____

Primary Care Physician (PCM): ____

Who referred you? ____

May I contact your PCM / Referring MD for ongoing regular updates? Yes No

REASON FOR YOUR APPOINTMENT - Briefly describe the reasons for which you are seeking help.

1. ____

2. ____

3. ____

Are you in pursuit of: Disability Divorce Custody Work Compensation Other?

When is the last time your felt well? ____

When did your problem start? ____

What do you think caused your problem? ____

____

What would you like to accomplish out of your time in therapy? ________________________________

____

____

How will you know when you no longer need treatment?____

Name Initials: _______ Date: ___________________

____

Do you have any questions for me in regard to the assessment / therapy process?

____

____

ABOUT YOURSELF

Describe yourself in three words: ____

How do you feel most of the time? ____

How do you express the feeling you just mentioned? _____________________________________

What do you consider to be some of your strengths? _____________________________________

____

What do you consider to be some of your weaknesses? ____________________________________

____

Three things you are grateful for: ____

____

What do you do for hobby or leisure activities? ____

____

EDUCATION / EMPLOYMENT

Education: Student High School / GED College Bachelors Masters PhD

Major: ____ GPA: ______________________

How was school for you academically?____

Do you have any learning disabilities? (E.g. dyslexia) Yes No

While in school, did you have any fears/anxiety, difficulties with authority, breaking rules, truancy…?

____

Did you have any disciplinary problems in school? Yes No _____________________________

Are you currently: Working Unemployed Retired Student Disabled

Name Initials: _______ Date: ___________________

Occupation: ____

Employer: ____ Location: ______________________

If unemployed, explain for how long and reasons for unemployment: ____________________________

____

Source of support if not employed: ____

Have you served in the military? Yes No - If so, what branch and when? ________________

Honorable discharge? Yes No

MEDICAL STATUS

Please rate your **physical health**: Poor Average Good Excellent

Do you **exercise** regularly? Yes No

When did you have your last **physical exam?** ____

When did you **last see a physician and for what reason**? ______________________________________

Any Surgeries? Yes No If yes, specify: ____

____

Do you have, or have you ever had, any **chronic or serious illness**? Yes No

If yes, please explain: ____

Do you have any **medical concerns**? Yes No If yes, please explain:

____

Any previous psychiatric hospitalizations? Yes No - If yes, when and describe the reason:

1. ____

2. ____

Have you previously received any mental health services (therapy, psychiatry…)? Yes No

If yes, describe your experience: ____

If yes, who was your previous therapist / practitioner? ____

Are you currently taking any Medications / Supplements? If yes, please list them:

____

Name Initials: _______ Date: ___________________

Please, check <u>only</u> what applies to you on the list here below.

PHYSIOLOGY	MOOD	THOUGHTS/PERCEPTION
Appetite Changes (increase / decrease)	Anxiety	Attention problems
Dieting	Fearful for no reason	Concentration problems
Binge eating / Purging	Panic Attacks	Memory problems
Weight Changes (increase / decrease)	Worrying	Difficulty w/ planning
Energy Changes (increase / decrease)	Feeling too energetic	Diff. problem-solving
Sleep Disturbance (increase / decrease)	Hyperactivity	Flashbacks
Nightmares	Feeling hopeless	"I'm better than others"
Shaking or Tremors	Feeling helpless	Hallucinations (A-V-T)
Slowed movements	Grief and loss	Out-of-body experiences
Difficulty with balance	Depressed mood	Difficulty making decisions
Muscle Rigidity	Withdraw/ Isolating	Missing blocks of time
Muscle Weakness	Crying spells	Self-Deprecation
Diff. with coordination	Feeling guilty	Racing thoughts
History of Seizures	Feeling shame	Daydreaming
Head injury	Mood swings	Fears/Phobias
Headaches	Lack of motivation	Obsessive thoughts
Pain/Discomfort	Loss of interest	Distrust of others
Incontinency	Feeling tired	"People want to hurt me"
Foul smell/taste	Irritability	Poor judgment
Gastrointestinal Issues	Unreasonable anger	Other (list below)
Dizziness	Other (list below)	
Sexual Dysfunction		
Other		

Name Initials: _______ Date: ___________________

BEHAVIOR	STRESSORS	SAFETY
Compulsive behaviors	Work problems	Thoughts to harm self
Restlessness/Agitation	School problems	Thoughts of dying
Diff. following instruct.	Absenteeism	Suicide attempts
Getting lost	Financial issues	Feel life is not worth living
Impulsivity	Legal problems	Thoughts to harm others
Reckless behavior (speed, drink/drive)	Loss of job	I have a Safety Plan
Problems with the law	Separation	
Property destruction	Divorce	
Gambling	Custody issues	**DAILY FUNCTIONING (DIFFICULTY WITH…)**
Self-Harm (e.g. cut, pick, burn…)	Medical issues	Doing dishes
Other (list below)	Traumatic experiences	Doing laundry
	Difficult relationships	Gardening/ House Work
	Difficulty making friends	Cooking
	Other (list below)	Cleaning
		Attending finances/bills
SUBSTANCES/ADDICTIONS	**QUANTITY / FREQUENCY**	Attend hobbies/Leisure
Alcohol		Self-Care (e.g. bathing)
Tobacco		Spirituality / church
Drugs (specify)		Other
Other		

FAMILY HISTORY

Has any family member had a nervous condition or emotional problem (including anxiety or mood problems? Yes No Explain:____

Alcoholism/Drugs? Yes No Suicide attempts? Yes No

Name Initials: _______ Date: ___________________

Relationship to you: ______________________

Family member need for therapy, medication, hospitalization? Yes No

Please describe: ____

RELATIONSHIP HISTORY

Describe your relationship with your spouse or significant other (if applies): _______________________

____

____

Do you have children? Yes No – If yes, please list names, gender and ages,

1. ____

2. ____

3. ____

4. ____

5. ____

List everyone who currently lives with you: ____

____

Do you have friends, other than your close family? Yes No

Describe your relationships with friends: ____

Who is your support system? ____

FAMILY BACKGROUND AND CHILDHOOD HISTORY

BIRTH: Did your mother have any problems with pregnancy/delivery with you? Yes No

____

What do you know about your birth? ____

____

Any major childhood illnesses? Yes No ____

During childhood, did you have any problems with (please check what applies to you)

Name Initials: _______ Date: ___________________

Learning Disability Aggression Fears Anxiety Family relationships

Hyperactivity Depression Panic Daydreaming Peer relationships

Please describe: ____

MOTHER: Living Deceased (what age? _____ ; your age _______) Occupation: ______________

Three words to describe her: ____

Describe your relationship with your mother: ____

____

FATHER: Living Deceased (what age? ____; your age ______) Occupation: _________________

Three words to describe him: ____

Describe your relationship with your father: ____

____

Describe your parents' relationship as a couple:

____

Did your parents ever separate or divorce? Yes No

SIBLINGS (list them in order of age, including yourself, and describe them with 3 words):

1. ____

2. ____

3. ____

4. ____

5. ____

Was there anyone else living with you in your family of origin? Yes No - If yes, who?

____

ATTACHMENT: As a child, who did you feel closest to (it can be a parent or not)? Describe:

____

SEPARATION /INDIVIDUATION: As a child, did you have difficulties (e.g. felt anxious) when separating from parents for brief periods of time? Yes No If yes, describe:

Name Initials: _______ Date: ___________________

During your childhood, did you live for any significant period of time with anyone other than your natural parents? Yes No If yes, who did you stay with? _____________________________

AUTONOMY: As a child, were you allowed to have some privacy and do things on your own, e.g. go over friends' house, have sleepovers …? Yes No Please explain: ___________________________

Which was your favorite childhood fairy tale / book? Who was your favorite character? ____________

What did your family do together for fun? ____

What were the consequences for misbehaving (observed or received)? ___________________________

Do you have any history of trauma (abuse, neglect, harsh punishments…)? Yes No

Did you witnessed it of receive it? Witnessed Received it

If yes, please describe where, when and by whom: ____

Did anyone in your immediate family die? Yes No Who and when? ___________________

ADOLESCENCE: How were you as an adolescent? Quiet or outgoing? Followed rules? Rebellious?

Did your parents discuss with you "hot topics", e.g. sex, opinions, how to pay bills…? Yes No

Did you have a boyfriend or girlfriend? Yes No If yes, at what age? ____________________

How did your parents react? ____

How was your relationship with your teen peers? ____

Name Initials: _______ Date: ___________________

ADULTHOOD: What age did you move out from your parents' home? ____________________________

Why? ____

Are you still close to your family of origin? Yes No If not, why? _______________________

ADDITIONAL INFORMATION

Other important facts that you think will be important for me to know:

____

____

____