Adult Intake Questionnaire

Name_____

Address_____

City/Zip code_____

Phone: Home_____ Work_____

Cell_____

Email_____

Emergency Contact: Name_____

Phone_____ Relationship_____

Referred by_____ Phone_____

REIMBURSEMENT If you would like me to provide you with a monthly receipt which you can forward to your insurance company or health savings plan to request reimbursement, please indicate below:
Monthly statement (circle one) Yes No

Age_____ Gender_____ Sexual Orientation_____

Date of birth_____ Preferred pronouns_____

Ethnicity (Circle one) Caucasian African American Latino/Latina Asian Other_____

Mixed ethnicity Please describe_____

Religious Background: Protestant Catholic Jewish Muslim Buddhist No affiliation Other

Marital status: Single, never married Married Separated Divorced Widowed Cohabiting

If divorced, when did you divorce your previous partner?_____

How long were you married?_____

If you are widowed, when did your spouse die?_____

Education: (Circle one) high school graduate GED college undergraduate degree

Master's degree Doctorate None of those listed, please explain_____

Occupation_____

Are you currently working? (Circle one) Yes No If yes, Part-time Full-time

Are you going to school now? (Circle one) Yes No If yes, Part-time Full-time

Name and Address of current job_____

_____

Names of persons living in your home and your relationship to them.

Name **Relationship**

Spouse/partner's occupation if applicable_____

Please provide the following information about your family.

Mother: Name_____

If deceased, year and cause of death:_____

If living, age and health status:_____

Her occupation (past occupation and/or present):_____

Father: Name_____

If deceased, year and cause of death:_____

If living, age and health status:_____ His occupation (past occupation and/or present):_____

Siblings:

Name Age Occupation Where does he/she live?

Where did you grow up?_____

Were your parents ever separated? Yes No (Circle one) If yes, when?_____

Did your parents get divorced? Yes No (Circle one) If yes, when?_____

Did either of them remarry? Yes No(Circle one) Who remarried and when?_____

At what age did you move out of your parents' home?_____

What is the highest degree you earned in school?_____

Did you ever leave a school you were enrolled in prior to completion? Yes No (Circle one)

If yes, give details, please: _____

Did you ever receive any special education services(i.e. academic tutoring, IEP, classroom accommodations, etc)? Yes No If yes, give details, please:_____

_____

If you were physically disciplined as a child, were you ever injured as a result? Yes No (Circle)
Did your parent or a person taking care of you ever purposefully injure you in other circumstances (that is when you were not being disciplined)/ Yes No (Circle one)
Did you ever have sexual contact with someone that you did not want? Yes No (Circle one)
Have you ever experienced or witnessed any traumas (events that felt life -threatening)? Yes No
Have you ever experienced physical or sexual abuse or assaults? Yes No (Circle one)

Work History

Type of job held How long?

_____

_____

_____

Family

If you have a partner or spouse, how long have you been together?_____

Please list names and ages of your children, if applicable:

Name	Age	Biological?	Name	Age	Biological?
_____		Yes No	_____		Yes No
_____		Yes No	_____		Yes No

Psychotherapy Please describe briefly the problem(s) that bring you in to see me. What are the symptoms, how intense are they, and how often do they occur?

_____

_____

_____

_____

Have there ever been problems like this before? Yes No (Circle one)
If yes, when?_____
Are you presently seeing another therapist? Yes No (Circle one) If yes, please give the following information:

Therapist's name_____ Date treatment began_____
Current therapist's address_____

Therapist's phone number_____

Have you previously been in psychotherapy or counseling, including individual, group, couples, or family therapy? Yes No (Circle one)

If yes, please share the following information: Therapist's name_____

Therapist's phone number(s)_____

Therapist's address_____City_____

State_____ Zip code_____ Dates

of Treatment:_____

Problems for which treatment was sought:

_____

_____

If you have been in psychotherapy before, was it helpful? Yes No (Circle one)

If yes, what was helpful?_____

If not, in what way was it unsatisfactory?_____

Has hospitalization or partial hospitalization for mental or emotional difficulties ever been recommended for you? Yes No (Circle one)

If yes, when and why?_____

Was the hospitalization voluntary? Yes No (Circle one)

Has a physician/psychiatrist ever recommended that you take medication for mental or emotional difficulties? Yes No (Circle one) If yes, did you take these medications? Yes No

What were the medications recommended, when and for what symptoms? _____

_____

Are you currently taking any prescribed medications? Yes No (Circle one) Please indicate what medications you are taking:

Medication Dosage When started Prescriber What is medication for?

_____

_____

_____

_____

Recreational or non-prescribed drugs: Have you ever used any drugs or medications other than prescribed? (This includes prescription medications, cannabis , PCP, LSD, amphetamines, cocaine, opiates, Ecstasy, and others) Yes No (Circle one)

Are you currently using? Yes No (Circle one) If yes, please list which ones and fill out the requested information:

Type Frequency/amount Duration How taken Using this currently?

_____

_____

_____

If you have used any substances listed above, do you feel they have caused any problems in your work, school, or relationships? Yes No (Circle one) If yes, please explain:

_____

_____

Alcohol: Do you drink alcohol? Yes No (Circle one) If yes, how much alcohol do you drink? _____ drinks per _____

Do you feel your drinking has caused any problems in your work, school, or relationships? Yes No (Circle one) If yes, please explain: _____

_____

Has treatment for drug or alcohol abuse ever been recommended to you? Yes No (Circle one) If yes, please describe the circumstances and give dates: _____

_____

Have you ever been treated for drug or alcohol abuse? Yes No (Circle one) If yes, please describe the provider, program, give dates and describe the outcome.

_____

_____

Have you ever had a physical fight with anyone, including your spouse or partner (including throwing things, hitting, shoving, etc.?) Yes No (Circle one)

Do you currently have, or have you had in the past, any serious, chronic or recurrent health problems or disabilities? Yes No (Circle one)

If yes, please describe: _____

_____

List dates of hospitalizations you have had for physical problems, if applicable:

Date Problem

_____

_____

_____

When was your last physical examination by a doctor?_____

What was the outcome?_____

Do any biological relatives have a history of psychiatric or emotional problems? Yes No If yes, which family members and what types of problems?

_____

_____

Have you ever been involved in a lawsuit? Yes No (Circle one)

If yes, please describe the circumstances and give dates. _____

_____

_____

Have you ever been arrested for a crime? Yes No (Circle one) If yes, please describe the circumstances and give dates.

_____

_____

Have you experienced any particular sources of stress in the last year? Yes No (Circle one)

If yes, please explain: _____

Are there any other health care professionals (e.g. physicians, psychotherapists, etc.) whom you feel might have information that would help in your treatment? Yes No (Circle one)

If yes, please give details: _____

_____

_____

Is there any other background information you think would be helpful for me to know?

Yes No (Circle one) If yes, please explain: _____

_____

_____

Signature_____

Date_____