Adult Intake Questionnaire

This questionnaire will help me understand your situation. *If you feel uncomfortable answering any question, you may leave it blank.* If you are unsure of an answer, you may give your best estimate.

Name:

_____ _____ _____
First Middle Initial Last

Home Address:

_____
Street Address City State Zip Code

Phone: (Home) _____ (Work) _____

(Cell) _____ (Other, please specify) _____

Email: _____ (*optional*)

Please circle preferred method of contact (home, work, cell, or e-mail)

Emergency Contact: (Name) _____

(Phone) _____ (Relationship) _____

Referral Source: How did you come to seek services with me?

_____ Health professional: Name _____

_____ Online: (please specify)_____

_____ Other: (please specify)_____

Reimbursement: Would you like to receive a monthly statement that you can forward to your insurance company to request reimbursement? (circle one) **Yes** **No**

If yes, is it OK to email statements to you? **Yes** **No, I prefer you to mail it to my home address**

Personal Information

1. Age: _____ 2. Date of birth: _____ 3. Gender (circle one): Male Female

4. Ethnicity (circle all that apply):

Caucasian	Black/African-American	Hispanic	South Asian
Middle Eastern	East Asian	Southeast Asian	Native American
Pacific Islander	Other: _____		

5. Religious background (circle one)

Protestant	Catholic	Jewish	Muslim
Buddhist	Hindu	No affiliation	Other: _____

6. Marital status (circle one):

Single, never married Cohabiting Married Widowed Divorced Separated

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

8. If married, what year did you get married? _____

9. If you have a partner or spouse, what is your spouse/partner's occupation?_____

10. If you are divorced, how long were you married? _____

11. If you are widowed, when and how did your spouse die? _____

12. If applicable, please list names and ages of your children:

First Name	Gender/Age	Where does s/he live?	Biological?
			Y/N
			Y/N
			Y/N

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

First Name	Relationship	Name	Relationship

Family/Social History

1. Mother

Biological parent? **Yes** **No** (circle one) Her occupation_____

Where was she born? _____

If not US, did she immigrate to US? **Yes** **No** If yes, when?_____

If living, where does she live now? _____

If living, age and health status _____

If deceased, year and cause of death _____

2. Father

Biological parent? **Yes** **No** (circle one) His occupation _____

Where was he born? _____

If not US, did he immigrate to US? **Yes** **No** If yes, when? _____

If living, where does he live now? _____

If living, age and health status _____

If deceased, year and cause of death _____

3. Did your parents marry? **Yes** **No** (circle one)

4. Did your parents separate? **Yes** **No** (circle one) If yes, when? _____

5. Did your parents divorce? **Yes** **No** (circle one) If yes, when? _____

6. With whom did you primarily live while growing up? (circle one)

Both Parents Mother Father Other (please specify) _____

7. Siblings

First Name	Gender/Age	Occupation	Where does s/he live?	Biological?
				Y/N
				Y/N
				Y/N
				Y/N

8. Where were you born? _____ 9. Where did you grow up? _____

10. Is English your first language? **Yes** **No** (circle one) If no, please specify first language _____

Education and Employment History

1. Are you going to school now? **Yes** **No** (circle one) Full-time Part-time (circle one)

If yes, what are you studying? _____

2. Are you working toward a degree? **Yes** **No** (circle one) If yes, what degree? _____

3. Number of years of education completed _____ (*Please count 1st grade as the 1st yr, so if you completed 4 years of high school that is 12 yrs, completed 4 years of college is 16, etc)*

4. What is your highest degree and when did you earn it? _____

5. Did you ever leave a school you were enrolled in prior to completion? **Yes** **No** (circle one)

If yes, give details:_____

6. Did you ever receive any special education services (e.g. academic tutoring, IEP, classroom accommodations)?

Yes **No** (circle one) If yes, give details: _____

7. Are you working now? (circle one): **Yes** **No** Full-time Part-time (circle one)

If yes, your occupation: _____

8. Employment history:

Type of job	How long?

9. Are you receiving or have you ever received medical or disability benefits? **Yes** **No** (circle one)

If yes, give details: _____

Current Problems and Treatment History

1. Please describe briefly what brings you in to see me.

_____

_____

_____

a. When did you start having these problems? _____

b. Have you ever had problems like this before? **Yes** **No** (circle one)

c. If yes, when? _____

2. Are you currently seeing another therapist/psychiatrist? **Yes** **No** (circle one)

If yes, please provide the following information:

Therapist's name _____ Date treatment began_____

3. Have you previously been in psychotherapy or counseling, including individual, group, marital or family therapy?

Yes **No** (circle one) If yes, please provide the following information:

Therapist's name(s)	Date(s) of treatment	Problem for which treatment was sought	Was it helpful? (Y/N)

4. Has a health professional ever recommended hospitalization or partial hospitalization for mental or emotional difficulties or for drug or alcohol abuse? **Yes** **No** (circle one)

5. Have you ever been hospitalized in an inpatient or partial hospitalization program for mental or emotional difficulties or for drug or alcohol abuse? **Yes** **No** (circle one) If yes, please complete the following chart.

When were you hospitalized?	For how long?	Reasons for hospitalization or partial hospitalization	Was it voluntary? (Y/N)

6. Do you *currently* take medications to treat mental/emotional difficulties or substance abuse prescribed by a physician/psychiatrist? **Yes** **No** (circle one) If yes, please complete the following chart. (Later in the questionnaire, you will be asked to list medications for medical conditions.)

Medication Name	Dosage/ Frequency	When started?	Name of Prescriber	Prescribed for what symptoms?

Medication Name (cont.)	Dosage/ Frequency	When started?	Name of Prescriber	Prescribed for what symptoms?

7. Are you currently involved in any other activities to help with your symptoms (e.g., massage therapy, acupuncture, chiropractor, meditation classes)? If yes, please describe.

_____

8. Do you currently take any herbal supplements or medicines? **Yes** **No** (circle one)
If yes, what do you take? _____

How often?_____ For what reason? _____

10. Have you ever made a suicide attempt? **Yes** **No** (circle one)

11. Have you ever purposely harmed yourself (cutting, burning, or other)? **Yes** **No** (circle one)

12. Please list medications you have taken *previously* to treat mental or emotional difficulties or drug or alcohol abuse:

_____

_____

13. Do you smoke cigarettes? **Yes** **No** (circle one) If yes, how much do you smoke? _____cigarettes per _____

14. Do you drink caffeinated beverages? **Yes** **No** (circle one) If yes, how many cups daily? _____

15. Do any biological relatives have any history of psychiatric, emotional and/or substance use problems? **Yes** **No**

If yes, which family members and what types of problems?

Hyperactivity/attention deficit disorder (ADHD) _____ Schizophrenia _____

Alcohol or drug abuse _____ Bipolar disorder_____

Panic attacks or phobias or anxiety _____ Other emotional problems _____

Depression _____ Neurological condition_____

Medical History

1. Do you now 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:

_____

2. Are you currently taking medications for any physical health problems? **Yes** **No** (circle one)

If yes, please complete the following chart.

Medication Name	When Started?	Name of Prescriber	Prescribed for what symptoms?

3. List dates of any hospitalizations for physical problems:

Date Problem

_____

_____

4. When was your last physical examination by a physician? _____What was the outcome? _____

5. Do you exercise? **Yes** **No** (circle one) If yes, how often? _____

Other Background

1. Have you ever been involved in a lawsuit? **Yes** **No** (circle one)

If yes, please describe the circumstances and give dates:

_____

2. Have you ever been arrested? **Yes** **No** (circle one)

If yes, please describe the circumstances and give dates:

_____

3. Have you experienced any particular sources of stress in the last year? **Yes** **No** (circle one)

If yes, please explain:

_____

_____

4. Are there any other health care professionals (e.g. physicians, psychotherapists) who have information that might help in your treatment? **Yes** **No** (circle one)

If yes, please provide that person's name and contact information:

_____

5. If there is any other information that would be helpful for me to know, please explain:

_____

_____

_____