Adult Intake Questionnaire

Instructions: To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank.

Personal History

Name _____ Age_____ Gender: M ___ F____
Address ___ _____
Street & Number *City* *State* *Zip*

Weight _____ Height_____ Eye color_____ Hair color _____ Race _____
Today's Date _____ Date of Birth _____ Years of education_____
Occupation _____ Contact Phone _____
Present Marital Status:

_____	never married	_____	separated
_____	engaged to be married	_____	divorced and not remarried
_____	married now for first time	_____	widowed and not remarried
_____	married now after first time	_____	other (specify)_____

If married, are you living with your spouse at present? Yes___ No___ Married how long? _____

Counseling History

Are you receiving counseling services at present? Yes_____ No_____
If Yes, please briefly describe_____
_____

Have you received counseling in the past?: Yes_____ No_____
If Yes, please briefly describe: _____

Is there any Family History of Behavioral Health or Substance Abuse?_____
If Yes, please briefly describe:_____

What is (are) your main reason(s) for this visit?_____
_____

How long has this problem persisted? _____

Under what conditions do your problems usually get worse?
_____

Under what conditions are your problems usually improved?
_____

How did you hear about this office, or who referred you?:_____

Medical History

Primary Physician's name: _____
Address: _____

List any major illnesses and/or operations you have had: _____ _____
_____

List any physical concerns you are having at present: (e.g., high blood pressure, headaches, dizziness, etc)

_____

_____

List any other physical concerns you have experienced in the past: _____
_____
_____

When was your most recent complete physical exam? _____
Results of physical exam: _____
_____

On average how many hours of sleep do you get daily?: _____

Do you have trouble falling asleep at night?: __No __Yes If Yes, describe_____
_____

Have you gained/lost over ten pounds in the past year?: __Yes __No, __gained __lost
If Yes, was the gain/loss on purpose? __Yes __No

Describe your appetite recently:
_____ poor appetite _____ average appetite _____ large appetite

What medications (and dosages) are you taking at present, and for what purpose?
Medication Purpose
_____
_____
_____
_____

Family History

Mother's age:_____ If deceased, how old were you when she died?: _____
Father's age:_____ If deceased, how old were you when he died?: _____
If your parents are separated or divorced, how old were you then?: _____
Number of brother(s) _____ Their ages _____ _____ _____ _____ _____ _____
Number of sister(s) _____ Their ages _____ _____ _____ _____ _____ _____
I was child number _____ in a family of _____ children.
Were you adopted or raised with parents other than your natural parents?:Yes___ No___
Briefly describe your relationship with your brothers and/or sisters:_____
_____

YOUR MOTHER (or mother substitute)
Briefly describe your mother: _____
_____

How did she discipline you? _____
_____

How did she reward you?_____
_____

How much time did she spend with you when you were a child? _____ much _____ average _____ little
Your mother's occupation when you were a child: _____

_____ *stayed home* _____ *worked outside part-time* _____ *worked outside full-time*

How did you get along with your mother when you were a child? _____ poorly _____ average _____ well

How do you get along with your mother now? _____ poorly _____ average _____ well

Did your mother have any problems (e.g., alcoholism, violence, etc.) that may have affected your childhood development?: Yes _____ No _____
(If Yes, please describe) _____
_____

Is there anything unusual about your relationship with your mother?:
Yes _____ No _____ (If Yes, please describe)_____
_____

Describe overall how your mother treated the following people as you were growing up:
(Circle one answer for each)

YOUR MOTHER'S TREATMENT OF:	Poor			Average			Excellent
1) YOU	1	2	3	4	5	6	7
2) YOUR FAMILY	1	2	3	4	5	6	7
3) YOUR FATHER	1	2	3	4	5	6	7

<u>YOUR FATHER</u> (or father substitute)
Briefly describe your father: _____
_____

How did he discipline you?: _____
_____

How did he reward you?: _____
_____

How much time did he spend with you when you were a child? _____ much _____ average _____ little

Your father's occupation when you were a child:_____
_____ *stayed home* _____ *worked outside part-time* _____ *worked outside full-time*

How did you get along with your father when you were a child? _____ poorly _____ average _____ well
How do you get along with your father now? _____ poorly _____ average _____ well

Did your father have any problems (e.g. alcoholism, violence, etc.) that may have affected your childhood development?: Yes_____ No_____
(If Yes, please describe) _____
_____

Is there anything unusual about your relationship with your father?: No _____ Yes _____
(If Yes, please describe) _____
_____

Describe overall how your father treated the following people as you were growing up:
(Circle one answer for each)

YOUR FATHER'S TREATMENT OF:	Poor			Average			Excellent
1) YOU	1	2	3	4	5	6	7
2) YOUR FAMILY	1	2	3	4	5	6	7
3) YOUR MOTHER	1	2	3	4	5	6	7

<u>Thoughts and Behaviors</u>

Please check how often the following thoughts occur to you:

1)	Life is hopeless.	____Never	____Rarely	____Sometimes	____Frequently
2)	I am lonely.	____Never	____Rarely	____Sometimes	____Frequently
3)	No one cares about me.	____Never	____Rarely	____Sometimes	____Frequently
4)	I am a failure.	____Never	____Rarely	____Sometimes	____Frequently
5)	Most people don't like me.	____Never	____Rarely	____Sometimes	____Frequently
6)	I want to die.	____Never	____Rarely	____Sometimes	____Frequently

7)	I want to hurt someone.	____Never	____Rarely	____Sometimes	____Frequently
8)	I am so stupid.	____Never	____Rarely	____Sometimes	____Frequently
9)	I am going crazy.	____Never	____Rarely	____Sometimes	____Frequently
10)	I can't concentrate.	____Never	____Rarely	____Sometimes	____Frequently
11)	I am so depressed.	____Never	____Rarely	____Sometimes	____Frequently
12)	God is disappointed in me.	____Never	____Rarely	____Sometimes	____Frequently
13)	I can't be forgiven.	____Never	____Rarely	____Sometimes	____Frequently
14)	Why am I so different?	____Never	____Rarely	____Sometimes	____Frequently
15)	I can't do anything right.	____Never	____Rarely	____Sometimes	____Frequently
16)	People hear my thoughts.	____Never	____Rarely	____Sometimes	____Frequently
17)	I have no emotions.	____Never	____Rarely	____Sometimes	____Frequently
18)	Someone is watching me.	____Never	____Rarely	____Sometimes	____Frequently
19)	I hear voices in my head.	____Never	____Rarely	____Sometimes	____Frequently
20)	I am out of control.	____Never	____Rarely	____Sometimes	____Frequently

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts that occur frequently or are a concern to you. Use the back of this sheet if necessary.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Symptoms

Check the behaviors and symptoms that occur to you more often than you would like them to take place:

_____ aggression	_____ fatigue	_____ sexual difficulties
_____ alcohol dependence	_____ hallucinations	_____ sick often
_____ anger	_____ heart palpitations	_____ sleeping problems
_____ antisocial behavior	_____ high blood pressure	_____ speech problems
_____ anxiety	_____ hopelessness	_____ suicidal thoughts
_____ avoiding people	_____ impulsivity	_____ thoughts disorganized
_____ chest pain	_____ irritability	_____ trembling
_____ depression	_____ judgment errors	_____ withdrawing
_____ disorientation	_____ loneliness	_____ worrying
_____ distractibility	_____ memory impairment	_____ other (specify)
_____ dizziness	_____ mood shifts	_____
_____ drug dependence	_____ panic attacks	_____
_____ eating disorder	_____ phobias/fears	_____
_____ elevated mood	_____ recurring thoughts	_____

Please give examples of how each of the symptoms that you checked impairs your ability to function (e.g., socially, emotionally, occupationally, physically, etc.). Use the back of this sheet if necessary.

_____
_____
_____
_____
_____
_____
_____

List your five greatest strengths:

1) _____
2) _____
3) _____
4) _____
5) _____

List your five greatest weaknesses:

1) _____
2) _____
3) _____
4) _____
5) _____

List your main social difficulties: _____

_____
_____

List your main love and sex difficulties: _____

_____
_____

List your main difficulties at school or work: _____

_____
_____

List your main difficulties at home: _____

_____
_____

Goals for Counseling_____

_____
_____
_____

How motivated are you to work on your issues:_____

_____
_____

THANK YOU FOR YOUR TIME IN COMPLETING THIS ASSESSMENT