3. Adult Intake Questionnaire

Name:

Today's Date: :

Age: Date of Birth: :

Address::

Main phone number::

Secondary phone number::

Email :

Who Referred you::

Reasons you are seeking services?:

Have you previously suffered from this issue?:

If Yes, enter previous therapist(s) seen for complaint, describe treatment:

Current Symptoms

(check all that apply)

- ☐ Anxiety
- ☐ Appetite Issues
- ☐ Avoidance

- [ ] Crying Spells
- [ ] Depression
- [ ] Excessive Energy
- [ ] Fatigue
- [ ] Self Harming Behaviors
- [ ] Hallucinations
- [ ] Impulsivity
- [ ] Irritability
- [ ] Libido Changes
- [ ] Loss of Interest
- [ ] Panic Attacks
- [ ] Racing Thoughts
- [ ] Suicidal Thoughts
- [ ] Sleep Changes
- [ ] Problems making or keeping friends

Any Additional symptoms not mentioned please list::

Medical History

Your current health: _____ excellent _____ good _____ fair _____ poor

Please rate the overall level of stress in your life: Very Low, Low, Average , High, Very High :

What do you consider to be the greatest source of stress at this time? :

Rate your overall level of happiness on a scale of 1-5 (1 = UNHAPPY, 5 = HAPPY). :

Current Medical Conditions:

What medications are you currently using?:

Past Medical Conditions:

Allergies:

Exercise Frequency and type:

Do you use alcohol? If so number of drinks and frequency:

Have you ever been treated for drug/alcohol abuse? If yes, when?:

Current or past substance abuse(please list if so):

Have you ever abused prescription drugs? If yes, which ones?:

Are you a past or present smoker? if so Length of time, number of cigarettes and frequency.:

Do you drink caffeinated beverages? If yes, how many per day?:

Previous medical conditions:

Family History

Were you adopted? If yes, at what age?:

How is your relationship with your mother?:

How is your relationship with your father?:

Siblings and their ages:

Are your parents married?:

Did your parents divorce? If yes, how old were you?:

Did your parents remarry? If yes, how old were you?:

Who raised you? Where did you grown up?:

Family member medical conditions:

Family member mental conditions:

Present Situation

Work:

Highest level of education completed:

Who lives with you?:

Are you married? If yes, specify date of marriage:

Are you divorced? If yes, specify date of divorce:

Prior marriages? If yes, how many?:

What is your sexual orientation?:

How is your relationship with your partner?:

Do you have child(ren)? If yes, how is your relationship with your child(ren)?:

If divorced with children, please explain custody situation :

Are you a member of a religion/spiritual group?:

Have you ever been arrested? If yes, when and why?:

Additional

Anything else you want the therapist to know?: