ADULT INTAKE FORM

Please answer the following questions to the best of your abilities. These questions are to help the therapist with the therapy process. This information is held to the same standards of confidentiality as our therapy. This questionnaire will take approximately 30 minutes to complete.

Name: Type text here
(Last) (First) (Middle Initial)

Name of spouse: parent or guardian (if minor):
(Last) (First) (Middle Initial)

Birth date: _____/_____/_____ Age:_____ Gender: Male / Female

Marital status: Never married Partnered Married Separated Divorced Widowed

Number of children: _____ Ages:_____

Current address: _____

_____

_____

Home phone:_____ May we leave a message? Yes No

Cell/other: _____ May we leave a message? Yes No

Email:_____ May we email you?* Yes No

*NOTE: Emails may not be confidential

Referred by:_____

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? Yes No

Reason for change:_____

Have you had any mental health services in the past? Yes No

Reason for change:_____

Are you currently taking any psychiatric prescription medication? Yes No

If yes, please list:_____

_____

Have you been prescribed psychiatric prescription medication in the past? Yes NoIf yes, please list:_____

_____

LIFE HISTORY QUESTIONNAIRE

NAME OF CLIENT: _____ DATE: _____

The information you provide will help in the planning of your counseling, and assist you and your therapist in clarifying your therapy goals. Please be as open and honest as possible. This questionnaire will be kept in your private confidential file.

Directions:

Please check all the items below that you currently experience or have difficulty with, and feel free to add any others at the bottom under "Other Concerns or Issues." You may add details as needed to clarify at the end of this questionnaire.

□ Abortion	□ Grieving, Mourning	□ Physical Problems
□ Abuse - emotional	□ Guilt	□ PMS
□ Abuse - neglect	□ Headaches, Pains	□ Poor Self-care
□ Abuse - sexual	□ Health, Illness	□ Pornography Use
□ Adoption	□ Hearing Voices	□ Procrastination
□ Aggression	□ Hostility	□ Relationship Problems
□ Alcohol Use	□ Hyperactivity	□ Relaxation
□ Ambition	□ Impulsive Spending	□ Re-marriage
□ Anger	□ Impulsiveness	□ Risk-taking
□ Anxiety	□ Incest	□ Sadness
□ Arguing	□ Indecision	□ School Problems
□ Attention Problems	□ Inferiority Feelings	□ Self Abuse - burning
□ Career Concerns	□ Infertility	□ Self Abuse - cutting
□ Childhood Issues	□ Inhibitions	□ Self Abuse - other
□ Children – care of	□ Interpersonal	□ Self Abuse - scratching
□ Children - custody	□ Irresponsibility	□ Self Abuse – pulling
□ Children - management	□ Irritability	□ Self-centeredness
□ Choices I've Made	□ Judgment Problems	□ Self-control
□ Chronic Pain	□ Laziness	□ Self-esteem
□ Codependence	□ Legal Matters,	□ Self-neglect, Poor Self-
□ Communication	□ Loneliness	□ Separation
□ Compulsive Spending	□ Loss of Control	□ Sexual Addiction
□ Confusion	□ Losses	□ Sexual Conflicts
□ Constant Conflicts	□ Loss of Interest In	□ Sexual Desire
□ Crying	□ Loss of Interest In Sex	□ Shyness
□ Deaths	□ Low Energy	□ Smoking
□ Debt	□ Low Frustration	□ Spirituality
□ Decision Making	□ Low Income	□ Step-parenting
□ Dependence	□ Low Mood	□ Stress
□ Depression	□ Marital Conflict	□ Stress-management

□ Distractibility	□ Marital Distance	□ Suspiciousness
□ Divorce/Separation	□ Marital	□ Temper Problems
□ Domestic Violence	□ Medical Concerns	□ Tension/Stress
□ Drug Abuse – over the counter	□ Memory Problems	□ Thought
□ Drug Abuse - prescription	□ Menopause	□ Threats of Violence
□ Drug Abuse – street drugs	□ Menstrual Problems	□ Tiredness
□ Drug Abuse - alcohol	□ Mixed feelings	□ Tobacco Use
□ Education	□ Mood swings	□ Unhappiness
□ Employment – lack of	□ Motivation	□ Violence
□ Employment - overdoing	□ Mourning	□ Violence – victim of
□ Employment Problems	□ Nail-biting	□ Weight and Diet issues
□ Employment - termination	□ Nervousness	□ Withdrawal - isolating
□ Emptiness	□ Nightmares	□ Work Problems
□ Exhaustion	□ Obsessions,	□ Worry All The Time
□ Failure	□ Outbursts	□ **Other concerns or issues:**
□ Fatigue, Low Energy	□ Oversensitive to	
□ Fears, Phobia	□ Oversensitive to	
□ Feelings of	□ Overweight	
□ Financial Troubles	□ Panic or Anxiety	
□ Friendship Problems	□ Parenting	
□ Gambling	□ Perfectionism	
□ Gender Identity	□ Pessimism	
□ Goals Not Being Met	□ Phobias	

Where did you attend high school? _____

Did you attend college/professional school? When, where, degree earned?

_____

Any plans to further your education? □ Yes □ No If so, when and what? _____

_____

What is your ethic background?

□ African/African American □ Asian American/ Chinese/ Filipino/ Japanese/ Korean/ Vietnamese
□ East Indian/Pakistani □ Latino/ Hispanic/ Mexican-American/ Puerto Rican
□ Middle Eastern □ Native American/ Alaskan Native
□ Polynesian/Micronesian
□ White/Caucasian □ Other (specify) _____

How much do you identify with your ethnic heritage? (Check one):
□ Not at all □ A little □ Somewhat □ Moderately □ Strongly

Religious/Spiritual preference**:** _____

_____

Do you consider yourself a religious person? □ Yes □ No or spiritual person? □ Yes □ No
Comment: _____

Faith: Group/Denomination in which you were raised: _____

Current Congregation: _____
How active are you? □ Inactive □ Slightly □ Moderate □ Very

Does your family speak a language other than English at home? (Check one):
□ Not at all □ Very little □ Sometimes □ Frequently □ Always
If "Sometimes" to "Always", what language is spoken? _____

Were you and both your biological parents born in the United States? □ Yes □ No □ Unsure
If no, who was foreign-born, where and what was the approximate age of immigration to the USA? (e.g. myself, Korea, 12; father Korea, 40;etc.) _____

_____

_____

Have you seen another therapist before? □ Yes □ No
If yes, who did you see? _____

Have you ever been hospitalized for psychological/emotional difficulties? □ Yes □ No
If yes, please note dates of hospitalization _____

_____

Are you or have you been on any medication for your psychological problems? □ Yes □ No

If yes, please note the type of medication, the dosage, and the dates you used this medication

_____

_____

Briefly describe the problem that brought you here.

_____

_____

_____

_____

Problem Intensity: How would you rate the intensity of the problem or concern that brought you in? (Circle the appropriate number):

1	2	3	4	5	6
Not intense		Moderately intense			Extremely intense

Problem Duration: Approximately how long have you had the current problem (in months or years)? ___

_____

Coping Strategies: In what ways have you attempted to cope with this problem_____

_____

_____

Expectations: What do you hope to accomplish by coming to therapy? Be as specific as possible.

_____

_____

_____

_____

_____

Have you been married/partnered before? □ Yes □ No If yes, when and for how long? _____

Please list the names of your children or dependents.

Names of Children	Date of Birth	Age	Lives With You?
_____	_____	_____	□ Yes □ No
_____	_____	_____	□ Yes □ No
_____	_____	_____	□ Yes □ No
_____	_____	_____	□ Yes □ No
_____	_____	_____	□ Yes □ No

List others who may live with you including their ages and occupations (e.g. brother 16, student, mother-in-law 55, etc.)

_____

_____

_____

Please check any past, present, or impending special problems in your family:

□ Deaths □ Divorce □ Frequent relocations
□ Serious illness □ Debilitating injuries/disabilities □ Alcohol/drug abuse
□ Psychiatric disorder □ Physical/sexual abuse □ Legal problems
□ Financial crisis/unemployment □ Attempted/completed suicide □ Eating disorders
□ Other _____

Please specify family member(s), with special problems, and approximate year of occurrence (e.g. mother, serious illness, 1998.) _____

_____

_____

_____

Would you like anyone else involved in the counseling with you? (family members, friends, etc.)

_____

Is there a concern about violence in your life today (either from you or towards you)? Please explain: ___

_____

Have you personally experienced significant family abuse?

□ None □ Unsure □ Emotional □ Physical □ Sexual

Have you personally experienced legal problems? □ Yes □ No

Did you experience learning problems in elementary or high school? (Check one):

□ None □ A little □ Some □ Substantial □ Lots, constant struggle

In general, how happy or adjusted were you growing up? (Check one):

□ Not at all □ A little □ About average □ Substantial □ Completely

How much is your family a source of emotional support for you now? (Check one):

□ None □ A little □ Somewhat □ Substantial □ Very strong

How much conflict in values do you currently experience with your parents? (Check one):

□ Very little or none □ Some □ Moderate □ Strong □ Extreme

Who in your family do you currently feel closest to? _____

_____

distant from?_____In most conflict with? _____

If you are married or in a committed relationship, are you currently in the process of separation or divorce? Please specify:

_____

What is the length of time apart? _____

How committed are you to making your marriage/relationship work? _____

_____

What changes are you willing to make for the sake of your marriage/relationship? _____

_____

_____

Describe any concerns regarding sexual or emotional intimacy with your spouse/partner. _____

_____

_____

_____

Please list any other information that you believe will be helpful for your therapist to know.

_____

_____

_____

_____

How is your physical health at present? □ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, diabetes, headaches, etc.) _____

Are you presently taking any prescribed or non-prescribed medication? □ Yes □ No

Please indicate _____

_____

Are you having any problems with your sleep habits? □ Yes □ No

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep

□ Disturbing dreams □ Other _____

How many times per week do you exercise? _____ About how long each time? _____

Are you having any difficulty with appetite or eating habits? □ Yes □ No

If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Poor appetite

□ Making myself vomit □ Significant weight change (last two months)

Do you regularly use alcohol? □ Yes □ No

In a typical month, how often do you have four or more drinks in a 24 hour period? _____

Do you consider your alcohol consumption a problem? □ Yes □ No □ Unsure

How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Rarely □ Never

Do you consider this drug use a problem? □ Yes □ No □ Unsure

Do you have any problems or worries about sexual functioning? □ Yes □ No

If yes, check where applicable:

□ Lack of desire □ Performance problem □ Difficulty maintaining arousal

□ Worried about sexually transmitted disease □ Sexual impulsiveness
□ Other _____

Have you ever experienced sexual assault, unwanted sex or uncomfortable touching?
□ Frequently □ A few times □ Once □ Never □ Unsure

Have you had suicidal thoughts in the last few months?
□ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past?
□ Frequently □ Sometimes □ Rarely □ Never

Have you ever intentionally inflicted any harm upon yourself? □ Yes □ No □ Unsure

In the past, how would you rate the quality of your peer relationships?
□ Very poor □ Unsatisfactory □ About average □ Good □ Excellent

Approximately how many significant intimate relationships (e.g. lasting 6 months or more) have you been involved in? _____ Are you in one now? □ Yes □ No □ I think so

Besides family members, approximately how many people can you really count on right now for friendship or emotional support? _____

List them below:

_____

_____

_____

Please enter any additional information about your life history here:

_____

_____

_____

SYMPTOMS CHECKLIST

Name: _____ Date: _____

Reason for seeking treatment:

What is the nature of the problem you are experiencing?

_____

_____

Briefly describe how the problem noted above causes you difficult.

_____

_____

Please check all of the behaviors and symptoms that you consider a problem:

□ Distractibility
□ Hyperactivity
□ Impulsivity
□ Boredom
□ Poor memory/confusion
□ Seasonal mood changes
□ Sadness/depression
□ Loss of pleasure/interest
□ Hopelessness
□ Thoughts of death
□ Self-harm
□ Crying spells
□ Loneliness
□ Low self worth
□ Guilt/shame
□ Fatigue
□ Change in appetite
□ Lack of motivation
□ Withdrawal from people
□ Anxiety/worry
□ Panic attacks
□ Specific fears
□ Social discomfort
□ Obsessive thoughts
□ Compulsive behavior
□ Aggression/fights
□ Frequent arguments
□ Irritability/anger
□ Homicidal thoughts
□ Flashbacks
□ Hearing voices
□ Visual hallucinations
□ Suspicion of others
□ Racing thoughts
□ Excessive energy
□ Mood swings
□ Sleep problems
□ Nightmares
□ Eating problems
□ Gambling problems
□ Computer addiction
□ Pornography problems
□ Parenting problems
□ Sexual problems
□ Relationship problems
□ Work/school problems
□ Alcohol/drug use
□ Recurring bad memories

Please mark any physical symptoms that you may be experiencing now with an "N", and any symptoms that you have experienced in the past with a "P".

	Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling
Head							
Neck							
Upper Back	☐	☐	☐	☐	☐	☐	☐
Mid-Back	☐	☐	☐	☐	☐	☐	☐
Lower Back	☐	☐	☐	☐	☐	☐	☐
Shoulder	☐	☐	☐	☐	☐	☐	☐
Arm	☐	☐	☐	☐	☐	☐	☐
Forearm	☐	☐	☐	☐	☐	☐	☐
Wrist	☐	☐	☐	☐	☐	☐	☐
Hand	☐	☐	☐	☐	☐	☐	☐
Ribs	☐	☐	☐	☐	☐	☐	☐
Buttock	☐	☐	☐	☐	☐	☐	☐
Hip/Thigh	☐	☐	☐	☐	☐	☐	☐
Leg	☐	☐	☐	☐	☐	☐	☐
Knee	☐	☐	☐	☐	☐	☐	☐
Ankle	☐	☐	☐	☐	☐	☐	☐
Foot	☐	☐	☐	☐	☐	☐	☐

On the diagram, please circle or mark any area(s) where you are experiencing pain or other discomfort.