Intake Questionnaire – Adult

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Practice Policies form and the HIPAA Notice of Privacy Practices. If you do not desire to answer a question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to our first session.

LEGAL NAME: _____ TODAY'S DATE: _____

PREFERRED NAME (If different): _____

SEXUAL ORIENTATION: _____ DATE OF BIRTH: _____

ADDRESS: _____

TELEPHONES: Cell: _____

FOR CONFIDENTIAL/PRIVATE MESSAGES:

Preferred Phone #: _____ Preferred Email: _____

Preferred Phone # for text: _____

EMERGENCY CONTACT:

Name: _____ Phone #: _____

REFERRAL SOURCE: _____

May I send them a thank you note for the referral? Yes ☐ No ☐

OCCUPATION (former, if retired): _____

_____

_

RELATIONSHIP STATUS:

☐Single ☐ Dating someone ☐ Married ☐Divorced ☐Other _____

PRESENT PARTNER/SPOUSE:

Name: _____

PAST & PRESENT MARRIAGE/S (names, years together, and statement about the nature of the relationship(s), i.e., friendly, distant, physically/emotionally abusive, loving, hostile):

_____
_

_____
_

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person):

_____

_____

_____

PARENTS/STEPPARENTS (name/age or year of death/cause of death, occupation, personality, how did they treat you, brief statement about the relationship):

Father: _____

_____
_

_____
_
Mother: _____

_____

_

_____

_

Stepparents: _____

_____

_

IF PARENTS DIVORCED:

Your age at the time: _____

How it affected you at the time:

_____

_

_____

_

SIBLINGS (name/age, if deceased: age and cause of death and brief statement about the relationship):

_____

_

_____

_

_____

PRIMARY CARE PROVIDER

Name: _____ Phone #: _____

PAST/PRESENT MEDICAL HISTORY (major medical problems, surgeries, accidents, falls, illness, etc.):

_____
_

_____
_

_____
_

CURRENT MEDICATION (list name, dosage, and reason for taking):

_____
_

_____
_

PRESCRIBING MD/PSYCHIATRIST (if different than care provider above)

Name: _____ Phone #: _____

PAST/PRESENT PSYCHOTHERAPY

List all mental health professionals you have worked with (please specify when, for how long, name, phone number, initial reason for therapy, beneficial or not, why it ended):

_____
_

_____
_

FAMILY MEDICAL HISTORY

History of mental illness/alcoholism/violence in family? ☐Yes* ☐No ☐Unsure

*If yes, please explain: _____

Describe any other illness that runs in the family: (i.e., cancer, epilepsy, etc.):

_____
_

_____
_

PRESENTING PROBLEM (be as specific as you can - when did it start, how does it affect you):

_____
_

_____
_

Estimate the severity of above problem: Mild ☐ Moderate ☐ Severe ☐ Very severe ☐

ALCOHOL/DRUG USE

Do you drink alcohol or use recreational drugs? *Yes ☐ No ☐

*If yes, describe quantity/frequency: _____

LIST ANY PAST/PRESENT DRUG/ALCOHOL ABUSE (and what treatment methods were taken, if any: i.e., AA, NA, inpatient care):

_____
_

_____
_

SUICIDE ATTEMPT/S, PSYCHIATRIC HOSPITALIZATION/S, AND/OR VIOLENT BEHAVIOR/S (describe ages, reasons/circumstances, how, etc.):

_____
_

_____
_

_____
_

DESCRIBE YOUR CHILDHOOD, IN GENERAL (familial relationships, school, neighborhood, relocations, behavioral/problems, abusive/alcoholic parent, etcl,):

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S, DIVORCE, OR CUSTODY DISPUTE/S?

☐Yes*☐No

*If yes, please explain: _____

CHECK ALL THAT APPLY:

- ☐ Headache
- ☐ High blood pressure
- ☐ Gastritis or esophagitis
- ☐ Hormone-related problems
- ☐ Head injury
- ☐ Angina or chest pain
- ☐ Irritable bowel
- ☐ Chronic pain
- ☐ Loss of consciousness
- ☐ Heart attack
- ☐ Bone or joint problems
- ☐ Seizures
- ☐ Kidney-related issues
- ☐ Chronic fatigue
- ☐ Dizziness
- ☐ Faintness
- ☐ Heart valve problems
- ☐ Urinary tract problems
- ☐ Fibromyalgia
- ☐ Numbness & tingling
- ☐ Shortness of breath
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Asthma
- ☐ Arthritis
- ☐ Thyroid issues
- ☐ HIV/AIDS
- ☐ Cancer
- ☐ Other: _____

CHECK ANYTHING YOU HAVE EXPERIENCED IN PAST 6 MONTHS:

- ☐ Increased appetite
- ☐ Decreased appetite
- ☐ Trouble concentrating

☐ Difficulty sleeping
☐Excessive sleep
☐ Low motivation
☐ Isolation from others
☐ Fatigue/low energy
☐ Low self-esteem
☐ Depressed mood
☐ Self-harm or cutting
☐ Anxiety
☐ Fear
☐ Hopelessness
☐ Panic
☐ Suicidal Thoughts
☐ Other: _____

FRIENDSHIPS, COMMUNITY & SPIRITUALITY (describe presence in your life currently):

_____
_

What gives you the most joy or pleasure in your life?

_____

What are your main worries and fears?

_____

What are your most important hopes or dreams?

What are your goals for therapy?

_____

Below, please add any other information you would like me to know about you and your situation.