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Adult Intake Questionnaire

Client Name: _____ Form completed by: _____

Referred by: _____

Date of Birth: _____ Age: _____

Address: _____ City: _____

Zip Code: _____ Ethnicity: _____

Phone Number	May I contact you here?	Check **one** preferred method of contact:
H:		
C:		
W:		
Email:		

Education: { } Grade school { } High school { } College { } Graduate school

Occupation: _____ Employer: _____

Emergency Contact Person: _____ Relationship: _____

Phone Number of Emergency Contact: _____

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I understand that counseling is a process that may take some time and there is no guaranteed benefit. What is shown in research is that it is important to have a trusting relationship with your therapist, provide honest answers, and understand that at times counseling is uncomfortable. Please inform me if this is troubling you. We can see how to resolve it as helpfully as possible. By signing this I understand the above statement and consent to treatment with Melissa Johnson, M.S., MFT.

_____ _____
Print client name Date

_____ _____
Client/legal guardian signature Relationship to client

Major reason for seeking help at this time? _____

_____

_____

_____

Have you had counseling in the past? { } Yes { } No

Name of counselor:	Dates of counseling:	Reason for counseling:

How long have you had these problems, symptoms or issues? _____

What have you already tried to resolve the problems, symptoms or issues? _____

_____

_____

What do you think needs to change to resolve the problems, symptoms or issues? _____

_____

_____

Have you ever been hospitalized for psychiatric reasons? { } Yes { } No

Dates?	Where?	Reason for hospitalization?

Do you have any family members who have been hospitalized for psychiatric reasons?

{ } Yes { } No

Who?	When?	Reason for hospitalization?

Are you currently under the care of a physician? { } Yes { } No

Name of physician: _____ Phone #: _____

Are you currently under the care of a psychiatrist? { } Yes { } No

Name of psychiatrist: _____ Phone #: _____

Are you currently taking any medications? { } Yes { } No

Name of Medication:	Dosage:	Prescribed by:

Have you ever attempted suicide? { } Yes { } No

Date:	Method:	Reason for attempt:

Do you have any family members who have attempted suicide? { } Yes { } No

Who:	When:	Reason for attempt:

Do you have any serious medical conditions? { } Yes { } No

Please list: _____

_____

_____

Do you use alcohol? { } Yes { } No

What kind:	How often:	How much:	When:

Is it difficult for you to stop or control the amount? { } Yes { } No

Do you use illegal substances? { } Yes { } No

(This is confidential information and will not be disclosed/reported to anyone.)

What kind:	How often:	How much:	When:

Is it difficult for you to stop or control the amount? { } Yes { } No

Have you ever had a DUI? { } Yes { } No If yes, when? _____

Has your drinking or drug use caused problems in the family? { } Yes { } No

Has it caused problems in your job? { } Yes { } No

Have you or anyone in your family been in a treatment program for substance use or abuse? { }Yes { } No

Who:	When:	Outcome:

Do you use any of the following?

Substance:	How much:	How often:	When:	Age started:
Caffeine				
Cigarettes				
Chewing tobacco				

Have you or anyone in your family had problems with criminal offenses or been in jail/prison? { } Yes { } No

Who:	Why:	When:	Current status:

Current Marital Status: { } Single { } Married { } Partnered { } Divorced { } Widowed

Name:	Length of long term relationship/ marriage:	Date:

FAMILY DATA:

Name	Relationship	City of residence	Check if living with you	Age	How do you get along?
	spouse/partner				
	child				
	child				
	child				
	mother				
	father				
	sibling				
	sibling				
	sibling				

Check all that apply for present or past:

Symptom:	Now	Past	Symptom:	Now	Past
Headaches			Dizziness		
Stomach problems			Sleep issues		
Memory problems			Confusion		
Racing thoughts			Paranoia		
Euphoria			Mood swings		
Excessive energy			Unusual thoughts		

Weird feelings			Suspicion		
Depression			Bingeing		
Weight loss			Weight gain		
Worthlessness			Hopelessness		
Feeling helpless			Low energy		
Crying a lot			Irritable mood		
Worrying a lot			Phobias		
Fears			Panic attacks		
Suicidal thoughts			Homicidal thoughts		
Gambling problems			Legal problems		
Financial problems			Poor concentration		
Recurring unwanted thoughts			Can't enjoy life		
Anger problems			Impulsive behavior		

Who is a part of your emotional support system?

Name:	Relationship:

What are your weaknesses? _____

_____

_____

What are your strengths? _____

_____

_____

Is there anything else I need to know about you? _____

_____

_____