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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: _____

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, LPCC.

Print client name

Date

Client/legal guardian signature

Relationship to client

Primary 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? _____

