



Adult Intake Questionnaire

Today's Date _____

Name _____ Date of Birth _____

Who referred you to me? How did you find me as your therapist (e.g., friend recommendation, doctor referral, Google search, Psychology Today directory, etc.)?

What is the reason you are coming in for counseling? Is there something specific, such as a particular event? Please be as detailed as you can.

What are your goals for our work together? What do you hope to gain out of counseling?

Marital Status

- Never Married
- Married
- Domestic Partnership Divorced
- Separated Widowed

Who currently lives in your home with you? (Name, Relation, Sex, Age)

What is your current occupation? How long have you been in the field? How satisfied are you with it?

Sleep, Eat and Activity

On a scale from 0 to 10 (0=very poor, 10=the very best), how would you rate your sleep?

How many hours of sleep do you typically get?

Do you feel rested when you wake up? If not, please explain.

Do you eat regular meals throughout the day?

- Yes, always
- Sometimes
- Rarely, I mostly snack

Do you exercise? If so, how many times per week?

- Yes _____
- No

Social

What do you like to do for fun or enjoyment? Do you have any hobbies?

Do you have close sources of support or an "inner circle?" If yes, who are they? First names or relation to you only, please.

Do you currently drink alcohol?

- Yes, how often? _____
- No

Do you smoke cigarettes or use any nicotine products?

- Yes, how often? _____
- No, I don't use any nicotine products.

Have you used any recreational drugs in the past 6 months?

- Yes, how often? _____
- Have used in the past, but not in the past 6 months
- Never used

Have you experienced any legal problems or been arrested?

- Yes _____
- No

Developmental and Childhood History

Who did you live with as a child?

How would you describe your childhood?

How did your parent(s)/guardian(s) discipline you as a child?

Medical History

Who is your primary care doctor? Please include your doctor's name and phone number.

On a scale from 0 to 10 (0=very poor, 10=the very best), how would you rate your health and why?

Please check if you have experienced any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Chronic fatigue |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Stomach issues | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Hormone-related problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Thyroid issues |
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart condition | <input type="checkbox"/> Other |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> None of the above |

Have you had any major surgeries, illnesses or accidents? if yes, please specify and include the date and what happened.

- Yes _____
- No

Are you currently experiencing chronic pain (ongoing pain lasting for longer than 6 months)?

- Yes _____
- No

Are you taking any prescription medications?

- Yes _____
- No _____

Do you have any allergies? If yes, please specify.

- Yes _____
- No _____

Emotional and Behavioral History

Please check any of the following you have experienced in the past 6 months:

- | | | |
|---|---|--|
| <input type="checkbox"/> Difficulty falling or staying asleep | <input type="checkbox"/> Difficulty leaving your home | <input type="checkbox"/> Flashbacks of negative events |
| <input type="checkbox"/> Difficulty getting out of bed | <input type="checkbox"/> Fear of certain objects or situations | <input type="checkbox"/> Large gaps in memory |
| <input type="checkbox"/> Frequent nightmares | <input type="checkbox"/> Repetitive behaviors (counting, checking doors, washing hands) | <input type="checkbox"/> Hearing voices when no one else is present |
| <input type="checkbox"/> Changes in eating/appetite | <input type="checkbox"/> Outbursts of anger | <input type="checkbox"/> Feeling that your thoughts are controlled or placed in your mind |
| <input type="checkbox"/> Voluntary vomiting | <input type="checkbox"/> Feelings of worthlessness | <input type="checkbox"/> Feeling that the television or radio is communicating with you |
| <input type="checkbox"/> Use of laxatives to lose weight | <input type="checkbox"/> Sadness | <input type="checkbox"/> Feeling as if you were outside yourself, detached, observing what you are doing |
| <input type="checkbox"/> Binge eating | <input type="checkbox"/> Fear | <input type="checkbox"/> Verbal abuse |
| <input type="checkbox"/> Excessive exercise to avoid weight gain | <input type="checkbox"/> Tearful or crying spells | <input type="checkbox"/> Physical abuse |
| <input type="checkbox"/> Persistent loss of interest in previously enjoyed activities | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Sexual abuse |
| <input type="checkbox"/> Withdrawing from other people | <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Other |
| <input type="checkbox"/> Spending more time alone | <input type="checkbox"/> Frequent worry | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Increased irritability | <input type="checkbox"/> Racing thoughts | |
| <input type="checkbox"/> Feeling anxious | <input type="checkbox"/> Difficulty catching your breath | |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Easily startled, feeling "jumpy" | |
| <input type="checkbox"/> Frequent feelings of guilt | <input type="checkbox"/> Difficulty concentrating or thinking | |

Is there a history of mental illness in your family? If yes, please specify their relation to you as well as their diagnosis if you know it.

- Yes _____
- No _____
- I don't know _____

Have you participated in therapy before? If yes, please specify when, the name of therapist, the reason for seeking help, and if you found it helpful.

- Yes _____
- No _____

Have you ever been hospitalized for a psychiatric issue?

- Yes _____
- No _____

Do you have, or have you ever had, suicidal thoughts?

- Yes _____
- No _____

Have you ever attempted suicide? Please list all attempts and your age when each happened, starting from the most recent event to the oldest event.

- Yes _____
- No _____

Do you have, or have you ever had, a problem with self-harm (e.g., cutting, scratching, hair-pulling, etc.)?

- Yes _____
- No _____

Do you have, or have you ever had thoughts or urges to harm someone else or damage their property?

- Yes _____
- No _____

Are you taking any psychotropic medications?

- Yes _____
- No _____

More About You

What else would you like me to know?
