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): ______________ PRONOUNS: _____________________

CURRENT GENDER IDENTITY: _____________ SEX ASSIGNED AT BIRTH: __________

SEXUAL ORIENTATION: ______________________ DATE OF BIRTH: _____________

ADDRESS: ____

TELEPHONES: Home: _________________________ Cell: _________________________

FOR ROUTINE MESSAGES:

Preferred Phone #: ____________________ Preferred Email: _________________________

FOR CONFIDENTIAL/PRIVATE MESSAGES:

Preferred Phone #: ____________________ Preferred Email: _________________________

Preferred Phone # for text: __________________________

HIGHEST GRADE/DEGREE: ___________ TYPE OF DEGREE: _______________________

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: __________________ Occupation: __________________ Education: _____________

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: ____

ESTIMATE HOW MANY HOURS PER DAY YOU SPEND ONLINE:

Social media: ______ Gaming: ______ Texting: ______ Browsing: ______

Work/School: ______ Other: ______

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?

____

____

Please add, on the other side of the page or on a separate page, any other information you would like me to know about you and your situation.