Initial Intake Questionnaire - Adult

Client Name: _____ **Date:** _____

What is your main reason for seeking counseling?

List the primary goals you would like to achieve through counseling

A
B
C
D

Please describe any significant *problems* or *stressors* , and *length of time* experiencing, in any of the following:

A. Mental or Emotional:

B. Family Relationships:

C. Work or School:

D. Health:

E. Legal Concerns:

F. Financial Pressures:

G. Friendships:

Please mark "S" for Satisfied and "D" for Dissatisfied in the following categories

__Housing/Living Situation
__Employment/Work Situation
__Family Support
__Education
__Spouse/Partner Support
__Relationship with Friends
__Ability to Care for Yourself
__Financial Situation

How often do you drink alcohol? What *type* of alcohol do you generally drink?

Do you use any drugs? If so *what* and *how often* ?

Initial Intake Questionnaire - Adult

What, if any, prescription medication do you take?

Medication	Condition treating	Dose	How Often	When Started

Do you take your prescribed medications regularly?

Do you suspect you may misuse any prescription medication?

How often do you drink caffeine? What *type?*

Do you smoke cigarettes? If so *how often* ? If you have *quit, for how long* ?

What over the counter medications do you use? How often?

What vitamins, herbs or supplements do you use? How often?

How often do you exercise?

How well do you sleep?

Are you concerned about your physical safety? If so, please explain.

Do you identify yourself as Heterosexual, Gay, Lesbian, Bi-sexual, or Other (if other, please explain)

Are you currently sexually active?

Do you have any concerns related to sex, sexual desire, sexual performance, etc.? If so, please explain

Do you have any history of trauma? (i.e., sexual assault, been in an accident, witnessed violence, history of abuse)

What, if any, religion do you belong to?

What is your activity level with your faith?

Initial Intake Questionnaire - Adult

Please check any symptoms that you have recently experienced:

- ☐ Muscles twitches
- ☐ Impulsiveness
- ☐ Hyperactivity
- ☐ Restlessness
- ☐ Over-aggressiveness
- ☐ Withdrawn from family or friends
- ☐ Stealing or Dishonesty
- ☐ Destructiveness
- ☐ Disorganization
- ☐ Trouble with Authority Figures
- ☐ Breaking Rules, Pushing Limits
- ☐ Injuring Self (i.e. cutting, hair pulling, burning, etc)
- ☐ Anger or Hostility
- ☐ Apathy
- ☐ Emotional Highs
- ☐ Feeling Guilty
- ☐ Helplessness
- ☐ Feelings of Rejections
- ☐ Low Self-Esteem
- ☐ Reduced Interest/Enjoyment in Life
- ☐ Easily Distracted
- ☐ Difficulty Making Decisions
- ☐ Chronic Pain
- ☐ Wish You Could Never Wake Up
- ☐ Forgetfulness
- ☐ Racing Thoughts or Speech
- ☐ Tendency to Go Off on Tangents
- ☐ Difficulty Speaking
- ☐ Racing Heart
- ☐ Fear of Abandonment
- ☐ Panic Attacks
- ☐ Flashbacks of Distressing Events
- ☐ Phobias
- ☐ Fear of Open Spaces
- ☐ Unsure of What is Real
- ☐ Feel Like You are Outside Your Own Body
- ☐ Hallucinations
- ☐ Obsessions
- ☐ Fears of Being Watched or Manipulated
- ☐ Murderous Thoughts or Wishes
- ☐ Eating Disorder -starving/binging/purging
- ☐ Emotional Eating
- ☐ Unable to Maintain Normal Weight
- ☐ Dissatisfied with Body Shape or Weight
- ☐ Concern Over Use of Any Substance(s)
- ☐ Persistent Desire for Any Substance(s)

Family History - Please check any of the following that apply and note if in: *A - Yourself, B - Your immediate family, C - The family you grew up in, D - Other relatives*

- ☐ Substance Abuse
- ☐ Other Addictions
- ☐ Sexual Abuse/Assault
- ☐ Physical Abuse/Assault
- ☐ Mental or Emotional Abuse
- ☐ Depression
- ☐ Anxiety
- ☐ Suicide or Attempted Suicide
- ☐ Mental Illness
- ☐ Family "Secrets"
- ☐ Infidelity
- ☐ Chronic Lying
- ☐ Children Out of Wedlock
- ☐ Abortion
- ☐ Divorce
- ☐ Religious Abuse
- ☐ Eating Disorders
- ☐ Teen Pregnancy