Adult Intake Questionnaire

_____

Form Completed by: _____

SS#___-___-_____ Referred by:_____
Date of Birth: _____ Age: _____
Address:_____
City: _____Zip Code:_____
Telephone: _____
Cell: _____
Work: _____
Where can I call and leave a message if needed?:_____

Education: ___ Grade School ___ High School___ College ___ Advanced Degree
Occupation: _____
Employer: _____
Emergency Contact Person: _____
Phone Number of Emergency Contact:_____
Relationship to Contact: _____

****

Major reason for seeking help at this time: _____
_____
_____
_____

Have you had counseling in the past? ___ Yes ___No
If yes, for what and when?
_____
_____
_____
_____

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

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

_____
_____
_____

What do you think need to change to resolve the problems, symptoms and issues?

_____
_____
_____

Have you ever been hospitalized psychiatrically? If yes please include when, where, why and duration of hospitalization. Include history of any family members also psychiatrically hospitalized:

_____
_____
_____

Are you currently under the care of a psychiatrist?_____
If yes who and phone number?_____

Are you currently taking any medications? If yes please provide:
Name of Medication Dosage Prescribed by:

_____
_____
_____

Have you ever attempted suicide? ___ Yes ___No. If yes include number of attempts, dates and precipitating events. Also include family history of suicide attempts:

_____
_____
_____

Do you have any serious medical conditions? ___Yes ___ No
If yes, please specify:

_____
_____
_____

Check all that apply for current or past:

	Current	Past		Current	Past
Headaches	_____	_____	Dizziness	_____	_____
Stomach problems	_____	_____	Sleep issues	_____	_____
Memory problems	_____	_____	Confusion	_____	_____
Racing thoughts	_____	_____	Paranoia	_____	_____
Depression	_____	_____	Mood Swings	_____	_____
Excessive energy	_____	_____	Unusual Thoughts	___	_____
Weird feelings	_____	_____	Suspicion	_____	_____
Euphoria	_____	_____	Binging	_____	_____
Weight loss	_____	_____	Weight Gain	_____	_____
Worthlessness	_____	_____	Hopelessness	_____	_____
Helpless	_____	_____	Low Energy	_____	_____
Crying a lot	_____	_____	Irritable mood	_____	_____
Worried a lot	_____	_____	Phobias	_____	_____
Fears	_____	_____	Panic Attacks	_____	_____
Suicidal thoughts	_____	_____	Homicidal thoughts	__	_____
Gambling Problems	_____	_____	Legal Problems	_____	_____
Financial Problems	_____	_____	Poor concentration	___	_____
Recurring thoughts	_____	_____	Can't enjoy life	_____	_____
Anger Problems	_____	_____	Impulsive Behavior	___	_____

Alcohol and other Substances:

Do you use alcohol?___Yes No_____
If yes, how much? _____ How often?_____
Age you started?_____

Do you use illegal substances?___Yes No_____
If yes, how much? _____ How often?_____
Age you started?_____

Has your drinking or drug use caused problems in the family? ___Yes __No
Has it caused problems in your job? ___Yes ____No
Is it difficult for you to stop or control the amount? ___Yes ___No
Have you ever had a DUI? ___Yes ___No If yes, when? _____

Have you or anyone in your family been in a treatment program for substance use or abuse? ____Yes ___No
If yes, include dates and outcome?
_____
_____
_____

Do you use tobacco products?___Yes No_____
If yes, how much? _____ How often?_____
Age you started?_____

Circle the caffeine products you consume regularly: Coffee, tea, cola, energy drinks, chocolate, and medications with caffeine. Average total cups/mgs daily?_____

FAMILY DATA:

Name	**City of Residence**	**Check if living with you**	**Age**	**How do you get along?**
Partner/ Spouse	_____	_____	____	____
Children	_____	_____	____	____
	_____	_____	____	____
	_____	_____	____	____
	_____	_____	____	____
Father	_____	_____	____	____
Mother	_____	_____	____	____
Siblings	_____	_____	____	____
	_____	_____	____	____

Have you or anyone in your family had problems with criminal offenses, been in jail/prison? ___Yes ___No. If yes, when, for what and current status?
_____
_____
_____

Marital Status:

___Single ___Married ___Partnered ___Divorced

___Widowed ___Length of each marriage or long term relationship.

Who is a part of your emotional support system?
Family:
_____
_____

Friends:_____
_____
_____
Other:
_____
_____
_____

What do you consider your strengths?
_____
_____
_____

Is there anything else you feel I should know about you or how you are doing currently?
_____
_____
_____

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. At these 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 Stephen Altbaum MFT.

Signature: _____ Date:_____