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Intake Questionnaire - Adult

Name _______________________________________ *Date of Birth*______________________

1. Please provide a brief statement explaining why you have scheduled this appointment:

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____
____
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2. Have you previously attended therapy/counseling? Yes _____ No ____

   Name of Provider ______________________________ Dates of service _______________

   Name of Provider ______________________________ Dates of service _______________

3. Have you been diagnosed with a medical or neurological problem? Yes _____ No ____

   If yes, please indicate the diagnosis (es) ____
   If yes, are you currently receiving services for this problem? Yes _____ No ____

4. Have you been hospitalized for psychiatric reasons? Yes _____ No ____

   If yes, when ______________________ and where ___________________________________
   Additional: when _____________________ and where ___________________________________

5. What *psychiatric* medications are you currently prescribed? None _________

Name of medication	Dose	Compliant? (Always, Sometimes, Rarely)

6. What *non-psychiatric* medications are you prescribed at this time? None _________

Name of medication	Dose	Compliant? (Always, Sometimes, Rarely)

7. What *psychiatric* medications have been prescribed in the past? None _________

Name of medication	Dose	Dates of use	Why was the prescription ended?

8. Please indicate with a 'check' those issues concerning you; you may use more than one check as a means of indicating the severity of the problem:

	Depression – sad, unhappy		Few friends
	Anxiety – nervous, worrying a lot		Anger
	Procrastination		Legal problems
	Work problems (i.e., dissatisfaction)		Poor concentration
	Work problems (i.e., unemployed)		Few interests
	Low self-esteem/lacks self-confidence		Victim of a violent crime or domestic abuse
	Physical complaints/medical problems		History of suicide attempt
	Quickly changing moods		Current Suicidal thoughts/attempts
	History or current drug/alcohol abuse		Dependent – Insufficient autonomy
	Inattentive – easily distracted		Recently divorced
	Easily irritated – grumpy a lot		Ongoing conflict with extended family
	Relationship/marriage problems		Unusual/bizarre behavior
	Financial problems		Poor social skills
	Disorganization		History of Emotional/Physical/Sexual Abuse
	Loss/death of someone close to you		Isolative – preferring to be alone
	Lack assertiveness skills		Loss (i.e., death in the family)
	Problems with parenting/child difficulties		Problems with regulating food or weight
	Problems with thinking (e.g., paranoid)		Cuts/burns or otherwise harms self
	Sexual Problem		

9. Demographic Information:

a. Marital status: Married Single Significant Other Divorced Widowed

b. Please indicate who resides is your home by name and relationship to you:

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10. How did you hear about our practice?

_____ Friend/Family member
_____ Psychologist/Psychiatrist/Social Worker
_____ Pediatrician/Medical Doctor
_____ Other (please describe) ________________________________

(optional) The name of the person who referred you __________________________