Adult Intake Questionnaire

*It is Important to complete this in its entirety and to have it with you at the time of first appointment

Date_____

Name_____DOB_____

Emergency Contact

Name_____ Relationship_____

Home Phone_____ Cell Phone_____

Presenting Problem

1. What is your major concern that led you to seek help?

_____
_____

2. What other concerns do you have?

_____
_____

Psychological History

3. Have you ever had a psychological evaluation or had intellectual testing? Y N If yes, describe when, with whom and what were the results.

_____
_____

4. Have you ever been in counseling, or have you ever sought help for these problems before? Y N If yes, enter the information below:

Date(s) and number of visits of *most recent* counseling._____
Who did you see?_____
Explain what happened and the results._____
_____

Date(s) and number of visits of any *earlier* counseling._____
Who did you see?_____
Explain what happened and the results._____
_____

5. If applicable, please carefully complete regarding medication for attention, behavior or mood problems.

Medication Name	_____	_____	_____
Dosage	_____	_____	_____
Reason Prescribed	_____	_____	_____
Dates Taken	_____	_____	_____
Prescribing Physician	_____	_____	_____
If discontinued, why?	_____	_____	_____

Medical Information

6. Who is your primary care physician? Name & address._____
_____

7. Have you been to the doctor in the last year? Y N If yes, what were the current concerns discussed and if any, what recommendations were made?_____
_____

8. How is your health currently? Are you currently taking medicine for other health problems? Y N If so, please list below.

Medication Name	_____	_____	_____
Dosage	_____	_____	_____
Reason Prescribed	_____	_____	_____
Dates Taken	_____	_____	_____
Prescribing Physician	_____	_____	_____
If discontinued, why?	_____	_____	_____

9. Check any of the following medical or physical problems that you have had?

	Childhood	Adolescent	Adult
Allergies or food sensitivities	_____	_____	_____
Frequent ear infections or cold	_____	_____	_____
Poisoning or drug overdose	_____	_____	_____
Serious illness or surgeries	_____	_____	_____
Vision/hearing difficulties (not glasses)	_____	_____	_____
Speech disorders	_____	_____	_____
Serious accidents/injuries	_____	_____	_____
Seizures	_____	_____	_____
Very sensitive to feel of labels, seams, Textures in clothes	_____	_____	_____
Bothered by loud or unexpected noises	_____	_____	_____
Very picky eater	_____	_____	_____
Headaches	_____	_____	_____
Allergies, if yes specify	_____	_____	_____

Have you ever suffered a head injury, concussion or traumatic brain injury (tbi)? If yes, explain_____
_____

Family History

10. Were you adopted? Y N If yes, what age?_____

11. Please respond to any problems from your early life that you may know of:

	Y	N	DK	Explain

Unusual circumstances for mother during Pregnancy	_____	_____	_____	_____
Developmental problems	_____	_____	_____	_____
Learning to crawl/walk	_____	_____	_____	_____
Did you speak words by age 2	_____	_____	_____	_____
Did you speak simple sentences by age 3	_____	_____	_____	_____
Were you physically active or on the go	_____	_____	_____	_____

12. Please respond to the following regarding your childhood/adolescent years:

	Y	N	Explain
Problems in family	_____	_____	_____
Separation/divorce/remarriage	_____	_____	_____
Health problem in family	_____	_____	_____
Alcohol/drug problem in parent	_____	_____	_____
Changes in living arrangement	_____	_____	_____
Homelessness	_____	_____	_____
Loss of income	_____	_____	_____

13. Please respond to the following regarding your family as an adult:

	Y	N	Explain
Problems in family	_____	_____	_____
Separation/divorce/remarriage	_____	_____	_____
Health problem in family	_____	_____	_____
Alcohol/drug problem in parent	_____	_____	_____
Changes in living arrangement	_____	_____	_____
Homelessness	_____	_____	_____
Loss of income	_____	_____	_____

14. Specify any of the following in your life:

	Y	N	Explain
Emotional/physical/sexual abuse	_____	_____	_____
Domestic violence	_____	_____	_____
Harassment to you or significant others	_____	_____	_____
Discrimination to you or significant others	_____	_____	_____
Exposure to disaster, accident or trauma	_____	_____	_____
Victim of a crime	_____	_____	_____

15. Specify any of the following in your life:

	Y	N	Explain
Death of a close friend	_____	_____	_____
Rejection by peers	_____	_____	_____
Target of bullying	_____	_____	_____
Frequent moves	_____	_____	_____

16. When growing up describe your relationship with your:

Mother_____

Father_____

Siblings_____

Friends_____

17. Currently how would you describe your relationship with:

Spouse_____
Children_____
Parents(if living)_____
Friends_____

Work Experience

18. Describe your work regarding your:
Job responsibilities_____
Job satisfaction_____
Past Problems (if any)_____
Current problems (if any)_____

19. What would you consider your greatest strengths?_____
_____

Educational History

20. What was your highest grade level reached or degree obtained?_____

21. What was your major area of study in college?_____

22. Where you ever on an Individualized Education Program IEP or a 504 Plan of Accommodation? Y N If yes, describe area of need_____
_____

23. Please "√ "any areas where you did well. Put an "X" where you had problems.

	Elementary/Middle School	High School	College
Reading	_____	_____	_____
Math	_____	_____	_____
Writing	_____	_____	_____
Grades	_____	_____	_____
Homework	_____	_____	_____
Behavior at school	_____	_____	_____
Peer relations	_____	_____	_____
Attitude about school	_____	_____	_____

24. Do you have problems with any of the following? Please check.

_____Difficulty sounding out words when reading
_____Problems tracking while reading (losing place, missing words)
_____Headaches or eyes hurting while reading
_____Difficulty remember what you read
_____Difficulty with math calculations
_____Difficulty understanding math concepts
_____Difficulty at written composition
_____Difficulty spelling
_____Poor handwriting (even when writing slowly)
_____Difficulty drawing or copying figures
_____Poor sense of direction
_____Poor balance or coordination, clumsy
_____Poor note taking or study skills
_____Test Anxiety

Attention, Oppositional, Anger, and Conduct Problems

25. Are any of these a current problem? If yes, please briefly explain.

	Y	N	Explain
Daydreaming/staying on task	_____	_____	_____
Restless or hyperactivity	_____	_____	_____
Impatience	_____	_____	_____

Following directions	_____	_____	_____
Being irritable/angry	_____	_____	_____
Aggressive feelings	_____	_____	_____
Feelings easily hurt	_____	_____	_____
Sadness/moodiness	_____	_____	_____
Lacking motivation	_____	_____	_____
Fear/Anxiety	_____	_____	_____
Worry	_____	_____	_____
Shyness	_____	_____	_____
Back/neck aches	_____	_____	_____
Compulsive behaviors	_____	_____	_____
Tics	_____	_____	_____
Problems with the law	_____	_____	_____
Feelings that life is not worth living	_____	_____	_____

26. Thinking of any of the most difficult or traumatic situations you have faced in your life, do you continue to show fear or avoidance behaviors when reminded of any of these events or being in similar situations? Y N If yes, please describe_____
_____

Other Health Related Behaviors

27. Are any of the following a particular concern? If yes, please briefly explain.

	Y	N	Explain
Difficulty with social cues/body language?	_____	_____	_____
Difficulty making small talk?	_____	_____	_____
Fascination with one topic?	_____	_____	_____
Difficulty with changing routine/activity?	_____	_____	_____
Sensitive to clothing?	_____	_____	_____
Sensitive to smells or tastes?	_____	_____	_____
Sensitive to light/glare?	_____	_____	_____
Clumsiness?	_____	_____	_____
Week joint or gross motor skills?	_____	_____	_____

28. Respond to the following behaviors. Do you……

	Y	N	If so, how much?
Smoke	_____	_____	_____
Soda (sweetened)	_____	_____	_____
Coffee/caffeinated drinks	_____	_____	_____
Alcohol	_____	_____	_____
Use drugs	_____	_____	_____

29. Is weight maintenance a problem? Y N If so, explain_____
_____

30. Describe you physical activity._____

31. How balanced is your diet in terms of getting adequate protein and not too much "junk" food?_____
_____

32. Have you tried any special diets?_____
_____

33. Please check any of the following sleep problems you experience:

____ Delays going to bed	____ Not rested after sleep	____ Teeth grinding
____ Difficulty falling asleep	____ Nightmares	____ Snoring
____ Difficulty waking in morning	____ Sleeping too much	____ Bedwetting

____ Physically restless sleep ____ Frequent waking ____ Sleep Apnea

34. Please respond to the following regarding family members, indicate with check mark:

	Parent	Grandparent	Child	Sibling	Other/Specify
Problems with attention	____	____	____	____	_____
Learning problems (reading, writing, math)	____	____	____	____	_____
Anger management	____	____	____	____	_____
Depression (needing medication)	____	____	____	____	_____
Anxiety (needing medication)	____	____	____	____	_____
Migraines	____	____	____	____	_____
Seizures	____	____	____	____	_____
Head Trauma	____	____	____	____	_____
Alcohol problems	____	____	____	____	_____
Drug abuse	____	____	____	____	_____
Other emotional problems	____	____	____	____	_____
Developmental disorders	____	____	____	____	_____

Home Life

35. List all family members living in your home

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

36. List your siblings and ages

Name	Age (If deceased, please indicate)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please include any additional information below that you feel is important for us to know.