

# Adult Intake Questionnaire

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

## Presenting problem and prior treatment

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

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2. What other concerns do you have?

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3. Is there a particular reason you are seeking an appointment now?

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4. Have you ever had a psychological evaluation or had intellectual or achievement testing at school?

No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, describe when, with whom and what were the results.

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5. Have you ever been in counseling, or have you ever sought help for these problems before?

No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, enter the information below.

Date(s) and number of visits of <b>most recent counseling</b> :
Who did you see?
Explain what happened and the results:
Date(s) and number of visits of <b>any earlier counseling</b> :
Who did you see?
Explain what happened and the results:

6. Have you ever taken medication for attention, behavior or mood problems? No \_\_\_\_ Yes \_\_\_\_\_

If yes, carefully enter the following information for each medication in the table below.

Medication			
Dose			
Reason prescribed			
Dates Taken			
Prescribing Physician			
Benefits			
Problems			
If discontinued, why?			

**Medical History**

7. Have you been to the doctor in the last year? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, were the current concerns discussed and if so, what recommendations were made? \_\_\_\_\_

8. How is your health currently? Are you being treated for anything? \_\_\_\_\_

9. Are you allergic to anything including medications? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, please describe. \_\_\_\_\_

10. What medical or physical problems have you had? Mark an X and then describe below.

	Birth to 5	6-12	13-18	19-24	25-50	50+
Allergies or food sensitivities	_____	_____	_____	_____	_____	_____
Ear infections, frequent colds	_____	_____	_____	_____	_____	_____
Poisoning or drug overdose	_____	_____	_____	_____	_____	_____
Serious illnesses or surgeries	_____	_____	_____	_____	_____	_____
Vision/hearing difficulties (not glasses)	_____	_____	_____	_____	_____	_____
Speech disorders	_____	_____	_____	_____	_____	_____
Serious accidents/Injuries	_____	_____	_____	_____	_____	_____
Any blows to the head or concussions	_____	_____	_____	_____	_____	_____
Any loss of consciousness or seizures	_____	_____	_____	_____	_____	_____
Very sensitive to feel of labels, seams, textures in clothes	_____	_____	_____	_____	_____	_____
Bothered by loud or unexpected noises	_____	_____	_____	_____	_____	_____
Very picky eater	_____	_____	_____	_____	_____	_____

11. Do you get headaches? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, please describe the type, frequency and severity? \_\_\_\_\_

12. List any medications you are currently taking for other health problems in the columns below.

Medication			
Dose			
Purpose			
Date Started			
Physician			
Side Effects			

**Developmental History**

13. Were there any problems or unusual circumstances during the pregnancy, delivery or first months of your life?  
No \_\_\_\_\_ Yes \_\_\_\_\_ Don't know \_\_\_\_\_ If yes, please describe.

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14. Were you adopted? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, at what age? \_\_\_\_\_

15. Were there any developmental problems including delay in learning to crawl, walk or talk?  
No \_\_\_\_\_ Yes \_\_\_\_\_ Don't know \_\_\_\_\_ If yes, please describe.

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16. As an infant, were you told you were difficult, demanding, hard to soothe, colic or had problems sleeping?  
No \_\_\_\_\_ Yes \_\_\_\_\_ Don't know \_\_\_\_\_ If yes, please describe.

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17. Were there any disruption or major difficulties that could have affected your bonding with your mother during the first three years?  
No \_\_\_\_\_ Yes \_\_\_\_\_ Don't know \_\_\_\_\_ If yes, please describe.

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18. As a child, were your said to have been extremely physically active or always "on the go"?  
No \_\_\_\_\_ Yes \_\_\_\_\_ Don't know \_\_\_\_\_ If yes, please describe.

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**Psychosocial history**

19. Please describe any of the following you have experienced.

Problem Areas	Age(s)	Nature of event and impact
<p><b>Problems in your family</b> while your were growing up, such as separation, divorce or remarriage; psychiatric, alcohol or drug problems of parent, death or serious health problems of family member; change in living arrangements</p>		
<p><b>Problems in your family</b> since being an adult, such as separation, divorce or remarriage; psychiatric, alcohol or drug problems of a spouse or child; death or serious health problems of family member; change in living arrangements</p>		
<p>Emotional, physical or sexual <b>abuse</b>; neglect, or exposure to domestic violence or on-going intimidation, harassment, discrimination</p>		

<p><b>Problems in social network</b> such as death or loss of close friends rejection by peers, or frequent moves causing loss of friends</p>		
<p><b>Educational problems</b> including learning problems, academic problems, inadequate schooling</p>		
<p><b>Problems with housing, living arrangements or sudden loss of family income</b>, such as homelessness, frequent moves or suddenly not having family income</p>		
<p><b>Medical problems</b>, illness or surgeries</p>		
<p><b>Problems related to the police, or interaction with the legal system</b>, being a victim of a crime or a ward of the court</p>		
<p><b>Exposure to disaster</b>, accidents or other trauma</p>		

**Social relations and support**

20. How well did you get along with your parents while growing up?

Mother: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Father: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

21. If you are married, how would you evaluate your marriage?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

22. How close are you to your parents and siblings now?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

23. How strong a network of friends do you have?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

24. Are you active in a faith and, if so, how strong a support does it provide?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

25. What other sources of personal strength do you call upon to face problems?

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

**School and Work History**

26. What is the furthest grade reached or highest degree attained in school? \_\_\_\_\_

27. What was the Grade Point Average in your last schooling? \_\_\_\_\_

28. Please mark with an "X" when any of the following has occurred.

	Elementary School	Middle School	High School	College
Reading difficulties	_____	_____	_____	_____
Math difficulties	_____	_____	_____	_____
Writing difficulties	_____	_____	_____	_____
Poor grades	_____	_____	_____	_____
Homework problems	_____	_____	_____	_____
Behavior problems at school	_____	_____	_____	_____
Peer Problems	_____	_____	_____	_____
Strongly disliked school	_____	_____	_____	_____
Resource or other remedial assistance	_____	_____	_____	_____
Special Education placement	_____	_____	_____	_____
On Individualized Education Plan (IEP)	_____	_____	_____	_____

29. Please circle any of the following that are current problems:

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|---|---|
| Difficulty learning to read, blend sounds or read smoothly    | Difficulty spelling                       |
| Problems tracking while reading (losing place, missing words) | Poor handwriting (even if writing slowly) |
| Difficulty remembering what was read                          | Difficulty drawing or copying figures     |
| Difficulty with math calculations                             | Poor sense of direction                   |
| Difficulty understanding math concepts                        | Poor balance or coordination, clumsy      |
| Difficulty at written composition                             |   |

Please describe your greatest strengths and any special abilities or talents.

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30. Have you ever had problems keeping jobs, getting along with supervisors or coworkers, or changing jobs frequently?

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**Attention problems**

31. What problems, if any do you have with daydreaming, staying on-task or being disorganized? At what age did you first notice this? Do the problems occur mainly at home, at school or work or in all places?

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32. What problems, if any, do you have with hyperactivity, stimulus seeking or feeling restless? At what age did you first notice this? Do the problems occur mainly at home, at school or work or in all places?

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33. What problems, if any, do you have with impulsivity, impatience or acting without thinking of consequences? At what age did you first notice this? Do the problems occur mainly at home, at school or work or in all places?

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**Oppositionality, anger and conduct problems**

34. What problems do you have with being asked to do small tasks or requests? Are you easily irritated by such requests, are you likely to remember the request and actually complete the request if you start it? How much do you feel that any problems in this area come from not liking to be told to do things versus being distractible or disorganized?

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35. What problems, if any, do you have with irritability and anger? When angry, are you more likely to let the anger go quickly or hold onto resentment?

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36. Do you ever become violent or destructive? Have you ever hurt anyone intentionally or threatened to kill someone? Have you ever been cruel to animals? What interest do you have in weapons?

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37. What problems, if any, do you have with getting into trouble, unlawful activity or delinquent actions that could cause legal consequences?

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38. In relating to others, what problems, if any, do you have in terms of lacking empathy, being manipulative or failing to show remorse when appropriate?

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**Depression**

39. What problems do you have with your feelings being too easily hurt? Are there any signs of problems with self-esteem? Are there particular things about yourself you feel especially bad about?

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40. What problems, if any, do you have with sadness, moodiness, withdrawing from friends or activities, appearing down, lacking motivation or enthusiasm, changes in eating pattern, loss of sex drive, crying easily or other signs of depression?

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41. Have you ever talked about wishing you were dead or discussed or attempted suicide?

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42. What problems, if any, do you have with fears, tension, anxiety, panic attacks, phobias, being very uncomfortable in new situations or extreme shyness? How has that changed over time?

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43. In what ways do stress or anxiety cause you physical symptoms such as back or neck aches, headaches, intestinal problems or dizziness? How has that changed over time?

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44. Has anything ever happened to you that when recalled causes you extreme distress? Are there any such events that continue to cause bad dreams? No \_\_\_\_\_ Yes \_\_\_\_\_ if yes, please describe

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45. Are there any ideas, fears or concerns about which you obsess or worry?

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46. Do you have any habits, rituals or other compulsive behaviors?

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47. What problems do you have with muscle or verbal tics? These are repetitive movements or noises such as eye blinking, facial twitching, or noises such as grunting, snorting, squeaking, or humming.

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**Substance use**

48. Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, how much? \_\_\_\_\_

49. Do you drink coffee? How much other caffeinated beverages do you drink?

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50. Do you drink alcohol? If so, describe how much and under what circumstances. Has anyone, including yourself, expressed concern about your drinking? Have you ever sought help to control or stop drinking? Was this ever a problem when you were younger? If you don't drink, what effect did it have if you ever tried it?

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51. Do you use any drugs? If so, describe how much and under what circumstances. Has anyone, including yourself, expressed concern about your use? Have you ever sought help to control or stop using? Was this ever a problem when you were younger? Did you ever try any drug that you did not like the effect?

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**Other health related behaviors**

52. How healthy is your diet? What problems, if any, have you had with sugar cravings, dieting or maintaining weight? Have you ever been tried on any special diets?

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53. How much activity or physical exercise do you get?

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54. (Females only) what problems, do you have with unusual depression, irritability or discomfort during the week or so before the menstrual period?

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55. Please circle any of the following sleep problems you experience and then describe the severity or frequency in the space below:

Difficulty waking in morning

Frequent waking during night

Snoring

Difficulty falling asleep

Nightmares (bad dreams)

Bedwetting

Not rested after sleep

Sleeping too much

Delays going to bed

Physically restless sleep

Teeth grinding

Sleep Apnea

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56. Anything else it would be helpful to know about?

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**Family History**

57. For each of the following, please identify any relatives (children, siblings, parents, grandparents, aunts or uncles) who may have had problems in these areas (i.e. "One of Mom's sisters took medication for depression.", "One of Dad's brother drank heavily from age 15 to 40 and then went into treatment").

Check here if father's family history is unknown. (    )    Check here if mother's family history is unknown. (    )

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Problems with attention including being distractible, hyperactive or impulsive.

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Problems in school or problems learning to read, write or do math.

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Problems with oppositionality, anger, violence or criminal behavior

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Depression or Anxiety

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Headaches/migraines/  
seizures/neurological problems

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Alcohol Problems  
Drug abuse

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Serious health problems

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Other mental or emotional illness

Thank you for completing this form!