Intake Questionnaire--Over 18 years old

Client Name: _____

Date: _____

Thank you for completing this questionnaire to help us better understand you. If at any point you feel like you need more space please write on the back of the sheet, or if you are completing electronically there is space for more information at the end. Feel free to skip any questions you need to.

Completed by:_____ Client's Date of Birth: _____

Why are you seeking help now, as opposed to earlier or later? What are your primary concerns?

Medical History

Allergies: _____

List ALL current medications, supplements, or regular over the counter medicines taken:

Name of medication	Dose	How often is it taken?

Are there any other psychiatric medications you have taken in the past?

Mark a ✓ next to current or past medical conditions for yourself and family members and provide more information if needed

✓	Condition	Who in the family and describe if needed
	Thyroid disease	
	Liver disease	
	Kidney disease	
	Diabetes	
	Cancer	

	COPD/Emphysema	
	Chronic fatigue	
	Hepatitis C	
	High cholesterol	
	Irritable bowel syndrome	
	Anemia	
	Frequent ear infections	
	Sickle cell disease	
	Broken bones	
	Bedwetting	
	Vitamin deficiency	
	Epilepsy/Seizures	
	Migraines	
	Head trauma/concussion	
	Asthma	
	Fibromyalgia	
	Chronic pain	
	Heart disease	
	High blood pressure	
	HIV	
	Gastrointestinal/GI concerns	
	Heart defects	
	Bleeding concerns	
	Dislocated joints	
	Snoring	
	Trouble waking up	
	Other	
	Other	

List any surgeries you have had:

How would you rate your physical health: ◯ Poor ◯ Satisfactory ◯ Good ◯ Very Good ◯ Excellent

List any specific health problems you are currently having:

How would you rate your sleep: ◯ Poor ◯ Satisfactory ◯ Good ◯ Very Good ◯ Excellent

Describe any sleep problems you are currently having:

How do you exercise and how often?

Please describe any challenges you have with food:

Brain/Mental Health and Substance Use Treatment History

Please tell us about any other therapy/counseling you have participated in:

Please tell us about seeing a psychiatrist or other provider for psychiatric medication management:

Please tell us about any inpatient or residential treatment you have received for your brain/mental health:

Please tell us about any drug or alcohol treatment you have participated in:

Have you or anyone in your family been diagnosed with or treated for:

Condition	**Who**	**Condition**	**Who**
Anxiety		Depression	
OCD		Bipolar Disorder	
Personality Disorder(s)		Eating Disorder(s)	
Post-Traumatic Stress		Schizophrenia	
Substance abuse		Suicide attempt(s)	
ADHD		Other:	
Other:		Other:	

Substance use:

Substance	**How much**	**How often**	**First used**	**Last used**
Tobacco/nicotine				
Alcohol				
Marijuana				
Methamphetamine				
Cocaine				
Stimulants (Adderall, Ritalin)				

Pain pills*				
Tranquilizer/sleep pills*				
LSD				
PCP				
Ectasy/MDMA/Molly				
Heroin				
Other hallucinogens or psychedelics (i.e. mushrooms, peyote)				
Other: _____				

*****Only those not taken by doctor order or taking more than prescribed

Please describe caffeine (pop, energy drinks, coffee etc.) intake:

Does anybody in the home use nicotine/tobacco products: _____

Behavioral concerns/addictions

Behavior	**How often?**	**Current or past concern?**
Gambling		
Pornography		
Sex		
Internet/Video Games		
Other, please explain		

Have you ever tried to hurt yourself? _____

Have you ever tried to harm others? _____

Family background

Were you adopted: ◯ yes ◯ no Where did you grow up? _____

Who raised you: _____ Are your parents still alive ◯ yes ◯ no

List your siblings and their ages:

Were your parents married ◯ yes ◯ no If your parents divorced/separated how old were you _____

Describe your current relationship status (i.e. married, partnered, single etc):

On a scale of 0 to 10, with 10 being extremely satisfied, how would you rate your current relationship _____

Describe any history with marriage or long-term partnerships:

List any children and their ages:

Religion/Spirituality:

Please describe for us your important traditions or activities:

Do you identify with a religion: _____

Education and Occupational History:

Tell us about your education history, where you went to school, and your overall experiences in education:

Current employment_____

Previous employment:

Legal History:

Describe any legal involvement your child has had, include divorce/custody arrangements. If the client is under guardianship we will need a copy of the court order:

Treatment Planning:

What are your strengths/what are you best at:

How would you describe your wants and needs:

What do you want from therapy?

How will things look when therapy is over?

If you have anything else you want to add, or you needed more space for anything above use this space:

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** _____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual?_____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	

XII.	19. Not knowing who you really are or what you want out of life?	0 ○	1 ○	2 ○	3 ○	4 ○	
	20. Not feeling close to other people or enjoying your relationships with them?	0 ○	1 ○	2 ○	3 ○	4 ○	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0 ○	1 ○	2 ○	3 ○	4 ○	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0 ○	1 ○	2 ○	3 ○	4 ○	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0 ○	1 ○	2 ○	3 ○	4 ○	