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? __________________

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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? ______________________________________

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____

Put an X next to current or past medical conditions for yourself and family members and provide more information if needed

X	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: ___________________________________

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____
____

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: ____

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____
____
____

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: ____

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____
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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: ____

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____

What do you want from therapy? ____

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____

How will things look when therapy is over? ____

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

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