

CLIENT INFORMATION

Adult Questionnaire

In order for us to be able to fully evaluate you, please fill out the following intake form and questionnaires to the best of your ability. We realize there is a lot of information and you may not remember or have access to all of it; do the best you can. Thank you!

CLIENT IDENTIFICATION

Name

Birth Date

Age

Sex

Religion

Marital Status

Children

Address

City

State

Zip

Phone #

Email:

MAIN PURPOSE OF THE COUNSELING (Please give a brief summary of the main problems)

WHY DID YOU SEEK COUNSELING AT THIS TIME? What are your goals in being here?

PRIOR ATTEMPTS TO CORRECT PROBLEMS & PRIOR PSYCHOLOGICAL HISTORY
(Please include contact with other professionals, medications, types of treatment, etc.)

MEDICAL HISTORY

Current medical problems:

Current Medications:

Current supplements/vitamins/herbs:

Any history of head trauma? (describe):

CURRENT LIFE STRESSES (include anything that is currently stressful for you, examples include relationships, job, school, finances, children)

SLEEP BEHAVIOR: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)

SCHOOL HISTORY

Last grade completed or degree granted:

Last school attended:

Average grades received:

Specific learning disabilities

Learning strengths

Any behavior problems in school?

What have teachers said about you?

ABUSE HISTORY: (answer only as much as you feel comfortable)

History of sexual abuse, molestation or rape?

Current sexual problems?

Any history of being physically abused:

FAMILY HISTORY

Family Structure (who lives in your current household, please give relationship to each):

Current Marital or Relationship Satisfaction (describe)

Significant Events (include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.)

Natural Mother's History:

age _____ occupation _____

School: highest grade completed _____

Learning problems

Behavior problems

Marriages

Medical Problems

Mother's Childhood atmosphere (family position, abuse, illnesses, etc)

Has mother ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose?

Mother's alcohol/drug use history

Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

Natural Father's History:

age _____ occupation _____

School: highest grade completed _____

Learning problems

Behavior problems

Marriages

Medical Problems

Childhood atmosphere (family position, abuse, illnesses, etc.)

Has father ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose?

Father's alcohol/drug use history

Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

Your Siblings (names, ages, problems, strengths, relationship with you)

Describe your relationships with friends

Describe yourself

Describe your strengths