

# Adult Intake Questionnaire

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*All information is considered confidential and will not be released without your written consent*

Name	DOB	Age
Address		
City	State	Zip
Home Phone	Cell Phone	Email

What brings you to my office? Briefly describe your current situation.

How long has this been occurring? What do you believe caused it? What have you tried to change it?

Who lives in your home with you?

Marital Status: \_\_\_\_\_ Spouse/Partner/Significant Other's First Name: \_\_\_\_\_

How would you describe your current relationship?

How many times have you been divorced? \_\_\_\_\_ Widowed? \_\_\_\_\_

**Please list all children and stepchildren (including those who do not live with you:**

Name of Child	Age	Sex	Do they live with you?	Describe your relationship <i>(How well do you get along?)</i>

Are you currently experiencing any difficulties in parenting your children?  Yes  No  
 If yes, please briefly describe:

**Family Psychological History:**

	Psychological/Emotional/Substance Use Issue <i>(depression, anxiety, ADHD, alcoholism, etc.)</i>	Any Treatment	Ever Hospitalized for These Issues
Mother			
Father			
Siblings			
Other			

In the space below, briefly describe your family of origin. Who were you raised by? Are your parents alive? If so, how old are they, how is their health, and how is your current relationship with them? If deceased, when did they die? If divorced/remarried, how old were you? As a child were you closer to your mother or father?

In a brief phrase, how would you describe your childhood environment?

Please describe any fearful/distressing/traumatic childhood experiences:

Please list all siblings, living and deceased, including name, age, where they live, and a description of your current relationship:

Please indicate by a check mark if the following have caused significant distress:

Ever	Last 2 weeks		Ever	Last 2 weeks	
		School problems			Legal problems
		Financial problems			Relationship problems
		Childhood issues			Memory problems
		Career problems			Sexual concerns
		Sadness/Depression			Don't need as much sleep
		Lack of enjoyment in activities			Racing thoughts
		Difficulty starting anything			Short attention span
		Change in appetite			Talking a lot (more than normal)
		Weight loss or gain			Feeling on top of the world
		Sleep problems (too much / not enough)			Irritability
		Fatigue / feeling tired			Worry/Anxiety
		Feelings of worthlessness			Jittery / jumpy / restless
		Guilt			Increased muscle tension
		Difficulty focusing / Easily distracted			Heart racing / chest pain
		Loss of interest in others			Trembling / shaking
		Difficulties making decisions			Smothering / shortness of breath
		Thoughts of hurting self			Choking sensation
		Suicidal thoughts			Nausea
		Urge to hurt someone else			Dizzy / faint / lightheaded
		Hopelessness			Feeling detached from self / feelings of unreality
		Eating out of control			Fear of losing control or going crazy
		Recurring thoughts that can't be controlled			Fear of dying
		Flashbacks (re-experiencing a past event)			Numbness or tingling
		Traumatic event			Chills or hot flushes
		Recent loss/grief			Avoiding public places
		Concern about weight			Concern others are judging / watching you
		See or hear things others don't			Unusual thoughts or ideas
		Intentionally skipping meals			Urges to repeat behaviors

**Have you or a family member ever been diagnosed with the following?**

Diagnosis	Self	Relative	Diagnosis	Self	Relative
Speech Problems			Premature birth		
Vision Problems			Lung/Respiratory problems		
Hearing Problems			Frequent ear infections		
Learning Disability			Headaches		
Developmental Delay			Chronic Pain		
Mental Retardation			Fibromyalgia		
Autism			Allergies		
Attention Problem			Diabetes		
Hyperactivity			High blood pressure		
Substance Abuse			High cholesterol		
Alcoholism			Heart disease		
Legal Problems			Cancer		
Victim of domestic violence			HIV/AIDS		
Sexual abuse or rape victim			Stroke or TIA		
Physical abuse victim			Seizures/Epilepsy		
Depression			Perpetrator of abuse		
Bipolar Disorder (manic-depression)			Memory problems		
Anxiety			Dementia/Alzheimer's		
Eating Disorder			Hazardous substance exposure		
Personality Disorder			Excessive exposure to lead		
Schizophrenia			Injury requiring hospitalization		
Suicide attempt			Head injury		
Other psychiatric illness			Surgeries		

Current health care provider: \_\_\_\_\_ Phone number: \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Reason for last visit: \_\_\_\_\_

**Please list all current medications (both prescription and over-the-counter):**

Medication	Prescriber	For	Dosage	Side effects

**Please indicate your usage of the following substances:**

Substance	Current	Past	Average Usage
Caffeine			
Tobacco			
Alcohol			
Marijuana			
Misuse of Prescription Drugs			
Inhalants			
Hallucinogens (LSD/Ecstasy/PCP/mushrooms)			
Opiates (Heroin/Morphine)			
Steroids (misuse only)			
Stimulants (Meth/Crack/Cocaine/Crank)			

**In the past 12 months, has your substance use repeatedly caused or contributed to:**

- Interference with home, work, or school obligations?  Yes  No
- Risk of bodily harm (drinking and driving, operating machinery, swimming)  Yes  No
- Run-ins with the law (arrests or other legal problems)  Yes  No
- Relationship trouble (family or friends)  Yes  No

**In the past 12 months have you:**

- Needed to use substances a lot more to get the same effect  Yes  No
- Shown signs of withdrawal such as tremors, sweating, nausea, or insomnia when trying to quit or cut down  Yes  No
- Not been able to stick to limits you set for yourself for substances  Yes  No
- Not been able to cut down or stop using substances  Yes  No
- Spent a lot of time using, anticipating using, or recovering from using  Yes  No
- Spent less time on other activities that had been important in the past  Yes  No
- Kept using substances despite problems  Yes  No

Have you ever been treated for substance use problems?  Yes  No

Dates	Provider	Focus of Treatment (Substance)

**Please list previous psychotherapy, counseling, or other treatment for personal or marital problems:**

Dates	Provider	Focus of Treatment

Have you ever been hospitalized for psychiatric reasons?  Yes  No

If yes, briefly describe when and for what reason: \_\_\_\_\_

Have you ever thought of taking your own life?  Yes  No

Have you ever attempted to hurt yourself?  Yes  No

Have you ever attempted to end your own life?  Yes  No

If yes, how many times, when, and by what method?

Are you currently in school? \_\_\_\_\_ If so, where? \_\_\_\_\_  
 What is your highest level of education (last grade or degree completed)? \_\_\_\_\_  
 When did you graduate, or if you are in school, when will you graduate? \_\_\_\_\_  
 What type of student were/are you? What kind of grades did you get?

**Did any of the following occur during your childhood?**

	✓		✓
Difficulty making friends		Participated in extracurricular activities	
Teased/bullied by others		Difficulty concentrating in class	
Suspended or expelled		Tutoring	
Getting into physical fights		Attended special program	
Repeated a grade/held back		Failed a class	
Truancy/skipped class frequently		Changed schools due to a move	
Refused to go to school		Removed from home due to abuse/neglect	
Skipped a grade		Other:	

**Please list your work history, beginning with your current job and working backward:**

Employer	Position Held	Dates	Reason Left

Were you ever in the military?       Yes    No

If yes: please list your branch, dates enlisted, discharge rank, discharge type, and any injuries you sustained while in the service:

Have you ever been arrested?       Yes    No

If yes, please list (with dates) all arrests, charges, convictions, and sentences you may have received:

Are you currently a party to any kind of lawsuit?       Yes    No

If yes, please elaborate:

What are your current hobbies, interests, or ways you use your free time?

Have you changed your level of involvement in any of these activities recently?  Yes  No

Do you exercise regularly?  Yes  No If yes, what do you do? \_\_\_\_\_

Please rate your current level of distress on a scale of 1 to 10 (10 being highest): \_\_\_\_\_

How do you cope with stressful situations?

What are some of your strengths?

Who is in your social support system, and how strong do you feel that support system is?

What do you hope to get out of therapy? What goals do you have?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

How were you referred to my office?

Is there anything else that is important for me to know that is not on this form? If so, please write about it here:

Signed:

Date: