Creative Counseling Solutions, LLC

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Adult Intake Questionnaire

Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____

Address: _____

_____

Home Phone: _____ OK to leave a message? Yes No

Work Phone: _____ OK to leave a message? Yes No

Cell Phone: _____ OK to leave a message? Yes No

Email: _____

Who referred you? _____

May we acknowledge the referral? Yes No

Reason you are seeking counseling at this time:

_____

_____

_____

_____

Describe any previous mental health services you have received (evaluations and therapy). Include the provider, diagnosis, and length of treatment: _____

_____

_____

_____

Present psychological difficulties; please list any that apply to you at this time.

____ Generalized Anxiety (across many situations)

____ Specific Fears/Phobias (list): _____

____ Panic attacks

____ Social Anxiety

____ Obsessive thinking or compulsive behaviors

____ Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc)

____ Sadness or Depression

____ Emotionally overwhelmed

____ Frequent crying

____ Loss of energy

____ Loss of pleasure in life

____ Self-injury/self-harm

____ Thoughts of suicide

____ Problems with eating

____ Problems falling asleep

____ Problems sleeping through the night

____ Trouble waking up

____ Fatigue, being tired during the day

____ Nightmares

____ Problems with attention or concentration

____ Racing thoughts

____ Problems making or keeping friends

____ Problems controlling temper

____ Relationship problems

____ Problems with job or school (please circle one or both)

____ Alcohol or drug problems

____ Financial problems

____ Legal situation

What do you wish to accomplish (what are your goals or priorities) in seeking counseling services at this time?

_____

_____

_____

_____

Family Information:

Marital status (circle one):

Single living with partner Married Separated Divorced Widowed

Rate quality of present relationship/marriage (if applicable):

___ very good ___ good ___ fair ___ poor ___ very poor

Your occupation: _____

Occupation of spouse/partner: _____

Children and ages:

_____

_____

_____

If divorced, what are the custody and visitation arrangements?

_____

_____

_____

Who currently resides in your home?

_____

_____

Any concerns that you have regarding your relationships with family members, or with anyone in your home?

_____

General Health:

Please rate your current health: ___ Excellent ___ Good ___ Fair ___ Poor

Primary Physician's name/address/phone number:

_____

_____

_____

When was your last physical exam? Any relevant findings?

_____

_____

Are there any physicians you see on a regular basis?

_____

_____

Describe any medical conditions that you have been diagnosed as having, and any medical procedures you have had (surgeries, etc):

_____

_____

List any medications (and the dosages) you take regularly. Include your prescriptions, over the counter medications, vitamins, and supplements.

_____

_____

_____

Any problems with sleep? Describe.

_____

_____

Any problems with eating? Describe.

_____

_____

Please rate the overall level of stress in your life:

___ Very low ___ Low ___ Average ___ High ___ Very High

What do you consider to be the greatest source of stress at this time?

_____

_____

Rate your overall level of happiness on a scale of 1-5 (1=Unhappy, 5=Happy): _____

What do you think would need to happen in order for you to feel happier?

_____

_____

Are you a past or present smoker? _____

Length of time, frequency, and amount per day? _____

Do you use alcohol, or have you in the past? _____

If yes, how often do you drink, and how much? _____

_____

Have you, or has anyone else, ever been concerned about your drinking (suggested you cut down or stop)? Please explain: _____

_____

Do you drink caffeinated beverages? _____

If yes, what type, how often, and how much? _____

_____

Family History:

Has anyone in the birth family had any of the following psychological disorders? Check all that apply, and list who (self, mother, father, sibling, child, other relative):

Yes	*Condition*	*Family Member*
___	Mental Retardation	_____
___	Speech or communication disorder	_____
___	Attention-deficit/Hyperactivity/impulsivity	_____
___	Learning problems/disabilities	_____
___	Autism Spectrum/Asperger's Disorder	_____
___	Sleep disorders	_____
___	Generalized Anxiety (in many situations)	_____
___	Social Anxiety	_____
___	Obsessive-Compulsive Disorder	_____
___	Phobias	_____
___	Depression	_____
___	Manic Depression/Bipolar Disorder	_____
___	Suicide attempts/suicide	_____
___	Schizophrenia/other psychosis	_____
___	Alcohol/substance abuse	_____
___	Seizures or other neurological disorder	_____
___	Genetic Disorder (Down syndrome, other)	_____

Other: _____

_____

Is there a history in the immediate or extended family of any significant medical difficulties, illnesses, or major surgeries? Please explain:

_____

_____

Educational History:

Your highest level of education completed: _____

Any problems with attention, learning, or behavior in school?

_____

_____

Any grades repeated? Please explain reason:

_____

Have you ever received services through special education (had an IEP)? If so, please explain:

_____

_____

Have you ever received accommodations in school through a 504 plan? If so, please explain:

_____

_____

Do you have any concerns regarding organization, memory, procrastination, or time management? If so, please explain:

_____

_____

If you have not completed your education at this time, what are your short-term or long-term goals for your education?

_____

Additional comments related to your education:

_____

Legal History:

Have you ever been, or are you currently involved in any type of legal situation? Please explain:

_____

Have you ever been arrested? Have you ever been on probation or diversion? Please explain:

_____