Steele Counseling • Debra Steele, LMFT

3166 N. Lincoln Ave., Suite 408
Chicago, IL 60657
Debra@SteeleCounseling.com • www.SteeleCounseling.com
847-877-7970

Adult Intake Questionnaire – *For Couples & Families, please complete separate questionnaires*

Background Information

1. Preferred name to be called/Nickname: _____

2. Gender identity (circle): Male, Female, Other, specify: _____

3. Occupation: _____

   How long have you worked at this position? _____

   Work hours: _____

   What is your job satisfaction? Use a scale from 1-5; 1=not satisfied and 5= fully satisfied: _____

4. Relationship Status (circle all that apply): never married, partnered, dating, married, separated, divorced, living-together, widowed, other: _____

   Answer **any** that apply to you:
   How long have you been in a relationship: _____

   When did you meet: _____

   When did you marry: _____

   When did you separate/divorce: _____

5. Is it OK to leave voice messages on any of the following phone numbers?
   (Check all that apply and write in number):
   __ Cell #: _____

   __ Work #: _____

   __ Other #: _____

6. Ethnic/Cultural Identity:_____

   What generation American are you (i.e.: what generation was born in the USA)?: _____

   What, if any, role does ethnic/cultural identity play in your life: _____

   _____

7. Religious/Spiritual Preference(s):_____

   What, if any, role does your religious/spiritual preference(s) identity play in your life: _____

   _____

8. Why are you seeking psychotherapy at this time? _____

_____

_____

9. How would you currently rate the problem/symptom(s) you are seeking help with at this time?
Use a scale from 1 to 5; 1=not intense and 5 = extremely intense _____

10. How long has the problem/symptom(s) been occurring? _____

11. How frequently has this problem/symptom(s) been occurring: Hourly, Daily, Weekly, Monthly, Yearly? _____

12. Have you experienced this problem/symptom(s) before now? If so, when? _____

13. Please list your current coping strategies in dealing with the problem(s):_____

_____

_____

14. Please list your current support systems (e.g.: family, friends, co-workers, faith, community, pets, coach, teacher, etc.): _____

In what ways are you receiving support from the aforementioned? _____

_____

15. Please list any recent life changes or transitions (e.g.: births, deaths, job loss/change, move, relationship status, school, friendships, finances, health, etc.): _____

16. Are you currently receiving other mental health services, counseling or psychotherapy elsewhere?
Yes **No** (circle one)
If **yes**, what services, where and how often? _____

_____

_____

17. Have you previously (i.e.in the past) received counseling or therapy before? **Yes** **No** (circle one)
If **yes**, When? _____ For how long? _____

For what purposes? _____

What services were helpful and why? _____

_____

What services were unhelpful and why? _____

_____

Mental Health

1. What, if any, mental health diagnoses do you have or have you had in the past (e.g.: bi-polar disorder, depression, panic disorder, ADHD, OCD, etc.)? _____

2. Are you currently experiencing any suicidal thoughts? Circle one: frequently, sometimes, rarely, never

3. Have you ever experienced suicidal thoughts? Circle one: frequently, sometimes, rarely, never

   When was the last time you experienced or had suicidal thoughts? _____

   Have you ever attempted suicide? _____ When? _____

4. Do you currently have a plan to hurt yourself? _____

5. Have you ever intentionally inflicted any harm on yourself (e.g.: cutting, hitting, burns, etc.)? **Yes** **No** (circle one)
   If **yes**, please explain: _____

   _____

6. Do you currently have a plan to hurt someone else? _____

7. Have you ever intentionally inflicted any harm on someone else? **Yes** **No** (circle one)
   If **yes**, please explain: _____

   _____

8. Have you ever been hospitalized for mental health issues? **Yes** **No** (circle one)
   If **yes**, please provide when, where and reason: _____

   _____

   _____

9. Are you currently taking any prescribed psychiatric medication(s)? **Yes** **No** (circle one)
   If **yes,** please list medication(s) and dosage: _____

   _____

10. Have you ever taken prescribed psychiatric medication(s) (in the past)? **Yes** **No** (circle one)
    If **yes**, please list medication(s) and dosage, when and reason: _____

    _____

    _____

Physical Health

1. How would you rate you current physical health? _____

2. What, if any, medical conditions or diagnoses do you have or have you experienced in the past (e.g.: Crohn's disease, high blood pressure, insomnia, infertility, cancer, heart conditions, etc.)? _____

   _____

3. Have you ever been hospitalized for a physical issue (e.g.: broken bones, surgeries, etc.) **Yes** **No** (circle one)
   If **yes**, please provide when, where and reason: _____

   _____

4. Do you have any difficulties with sleep? **Yes** **No** (circle one)
If **yes**, what and how often? _____

5. Any recent appetite or eating changes? **Yes** **No** (circle one)
If **yes**, circle **any** that may apply: weight gain, weight loss, food restriction, binging, eating more, eating less
And, please explain: _____

6. Do you or anyone else have concerns about your weight and/or relationship with food? **Yes** **No** (circle one)
If **yes**, circle **any** that may apply: weight gain, weight loss, food restriction, binging, eating more, eating less
And, please explain: _____

7. Do you exercise? **Yes** **No** (circle one)
If **yes**, what is the duration (in minutes/hours) of your typical exercise session? _____

How many times per week? _____

8. Do you have any problems or worries about sexual functioning? **Yes** **No** (circle one)
If **yes**, please explain: _____

Substance Use

1. Do you smoke cigarettes? **Yes** **No** (circle one)
If **yes**, how much and how often? _____

2. Do you smoke pot/marijuana? **Yes** **No** (circle one)
If **yes**, how much and how often? _____

3. Do you currently drink alcohol? **Yes** **No** (circle one)
If **yes**, how many drinks per week on average do you consume? _____

4. Has anyone in your family currently have or has had, in the past, a substance abuse problem and/or an alcohol abuse problem? **Yes** **No** (circle one)
If **yes**, please explain: _____

_____

5. Are you currently taking any other substance(s) (e. g: recreational drugs, non-prescribed psychiatric or general medication(s), illicit substances, etc.)? **Yes** **No** (circle one)
If **yes**, please list substance(s) and dosage: _____

_____

And, approximately how many times per week are you are you consuming the abovementioned substance(s)? ___

6. Do you or anyone else have concerns about your drug and/or alcohol use? **Yes** **No** (circle one)
If **yes**, please explain: _____

_____

Family Background

1. Please list current members of your family, including significant others if not married:

Name & Relationship to You	Age or Date of Birth	Occupation/Year in School

2. Please list any information about your family relationships (e. g.: divorce, extended family issues, past abuse or trauma experienced or witnessed as a child, etc.): _____

_____

_____

3. Have any of your family members ever been diagnosed with an emotional disorder, such as depression, anxiety, bi-polar disorder, etc.? **Yes** **No** (circle one)
If **yes**, please explain: _____

_____

4. Have any of your family members ever been diagnosed with any learning issues or disabilities?
Yes **No** (circle one)
If **yes**, please explain: _____

_____

Legal Concerns

1. Are you or any immediate family members currently involved in any court case? **Yes** **No** (circle one)
If **yes**, please describe: _____

_____

2. Are you currently involved in divorce mediation or a custody case? **Yes** **No** (circle one)
If **yes**, please describe: _____

_____

3. Is there currently a custody agreement in place? **Yes** **No** (circle one)
If **yes**, please describe agreement: _____

_____

What are your main goals for therapy:

1._____

2._____

3._____

Please list anything else you would like me to know about you or your family before we initiate therapy services:

_____

_____

_____

_____

_____

_____