



201 W Lakeway Rd. Ste 400
Gillette WY, 82718

Office:(307)686-0808
FAX: (888)491-5505

Barbara Daley, Psy.D.
Sarah Hayworth, LPC
Cora Martorelli, LPC
Kevin Wood, LPC

ADULT INTAKE QUESTIONNAIRE

Thank you for selecting Meadowlark Counseling, LLC to help meet the needs of you and your family, we appreciate the opportunity to assist you in this important process.

Please download and email to office@meadowlarkgillette.com prior to your appointment for your provider to review. If you are not able to do so, please bring the questionnaire with to your appointment. If at any time in this process you have any questions, please contact us.

We look forward to serving you,

Meadowlark Counseling, LLC

ADULT INTAKE QUESTIONNAIRE

So that we can best assist you *please fill out this form with information relevant to your treatment* at Meadowlark Counseling.

Meadowlark Counseling, LLC will hold information provided by you strictly confidential and will only release information in accordance with HIPPA guidelines and as mandated by law.

PLEASE PRINT

What is your name? _____

Please describe your reason for seeking help at Meadowlark Counseling.

Please rate on a scale from (none to severe) any issues you are having with the following:

Depression:	none	1	2	3	4	5	6	7	8	9	10	severe
Anxiety:	none	1	2	3	4	5	6	7	8	9	10	severe
Physical Pain:	none	1	2	3	4	5	6	7	8	9	10	severe

Have you served in the Military: YES NO

Information about military history relevant to treatment:

Are you involved in any Legal issues? YES NO

If Yes, who is your current Case Worker? _____ Case Number? _____

Information about legal history relevant to treatment:

Are you involved with DFS? YES NO

If Yes, who is your current Case Worker: _____

Information about involvement with DFS relevant to treatment:

Please check Current Marital Status: Married Divorced Separated Widowed Single Cohabitants

If married, how long? _____ If divorced, how long? _____

How many times have you been married? _____

Current Spouse/Significant Other: Name _____ Age _____

Who lives in your home with you?

Name	Age	Sex	Relationship
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Who are your Emotional Supports? (Such as people, animals, or spiritual resources, etc.)

Please make a check by your Highest Level of Education:

(Did Not Finish High School) (High School Degree) (GED) (Trade School)

(Some College) (AA or BA) (Graduate Level College)

1. Did you ever repeat a grade? YES NO If yes, what grade(s)?: _____
2. Were you ever expelled or suspended? YES NO If yes, When?: _____
3. Were you ever identified with a learning disorder in school? YES NO
If Yes: What kind?(check all that apply) Math Reading Writing Speech Attention Dyslexia
4. How are/were your grades? (check one) Above Average Average Below Average

Please rate your Current Health (Bad to Great):

Current Health: BAD 1 2 3 4 5 6 7 8 9 10 GREAT

Name of primary care physician: _____

Phone Number: _____

List any medical conditions past or present, including head injury, that are relevant to treatment:

Please list any Substance Abuse issues that are relevant to treatment:

Are you currently Employed? YES NO

If Yes, How long and with whom?

Information about Employment relevant to treatment:

If No, and it is relevant to treatment, please explain:

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