Advanced Counseling and Testing Solutions, LLC

2121 Oregon Pike, Suite 201
Lancaster, PA 17601
T: 717-208-6599 F: 717-208-7753
www.ACTSofLancaster.com

4 Wellington Blvd., Suite 101
Wyomissing, PA 19610
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Adult Intake Background Data

This questionnaire is to gather important background information on you that will assist us in providing you high quality care. Please answer the following questions to the best of your ability.

Date: _____

Name: _____

Date of Birth:_____

Address:

_____

_____

Home Phone: _____ Cell Phone:_____

Work Phone: _____ Email:_____

Gender Identity: Male_____ Female_____ Transgender (___MTF)____FTM)_____Gender Neutral

_____Non-Binary _____Additional category (please specify):_____

Emergency Contact:_____

Relationship:_____

Phone:_____

Form Completed by: (if someone other than patient) Name and Relationship :

_____

Presenting Problem

1. Please tell us the purpose for which you are seeking outpatient mental health services: (please select all that apply)

___ Anger Management
___ Anxiety
___ Depression
___ Fear/Phobias
___ Confusion
___ Work Issues
___ Sleep Problems
___ Sexual Concerns
___ Stress
___ Family/Marital Problems
___ Alcohol/Drugs

___ Other Mental Health Concerns (specify):_____

Mental Health / Drug and Alcohol Treatment History

Name of Agency/Therapist	Date/Year	Reason for Treatment

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Please Describe Your Experience With The Above Treatments If Applicable:

_____
_____
_____
_____
_____

Do You Currently Have A Psychiatrist? Yes No

If Yes, What Is His/her
Name:_____

If Yes, ***Please complete the release of information form and include their name and address***

Substance Use History

1. Do you currently drink alcohol? Yes No
2. Have you consumed alcohol in the past? Yes No
3. Are you or others concerned about your drinking Yes No
4. Do you currently use drugs? Yes No
5. Have you used drugs in the past Yes No
6. Are you or others concerned about your drug use? Yes No
7. Do you smoke cigarettes or use other forms of nicotine Yes No
8. If yes, how much per day? _____
9. Are you interested in quitting? Yes No
10. 10. Do you drink caffeine Yes No
11. If yes, how much per day? _____

Medical History

1. Do you have a family or primary care physician Yes No

2. May we contact him/her Yes No

If yes: ***Please complete the release of information form and include their name and address***

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Have you had any of the following:

1. Past or present medical illnesses? Yes No
2. Hospitalization/Operations Yes No
   If Yes, list year and type:

   _____

   _____
3. Head injuries or loss of consciousness Yes No
   If Yes, please describe:

   _____

   _____
4. Are you currently taking any medications? (Including Psychiatric Yes No

   Prescriptions, Supplements, Herbs or Over-The-Counter Medications) If Yes, please list:

Medication	Dosage/How Many Times Per Day

Family Medical History

1. Is there any history in your family of: If Yes, whom (please list)

Alcoholism/Alcohol Abuse	Yes	No	_____
Drug Abuse or Dependence	Yes	No	_____
Heart Disease	Yes	No	_____
Diabetes	Yes	No	_____
High Blood Pressure	Yes	No	_____
Psychiatric Problems	Yes	No	_____
Suicide Attempts	Yes	No	_____

Family Background/Family of Origin

1. How old is your father? _____ If deceased, at what age? _____
2. Does/Did he have any health problems? Yes No

   If yes, describe:

   _____

   _____

Quality of relationship with him:

_____

3. How old is your mother? _____ If deceased, at what age? _____

Does/Did she have any health problems? Yes No

If yes, describe:

_____

_____

Quality of relationship with her:

_____

4. If any, how old is/are your brother (s) and/or sister(s)?

_____

If deceased, at what age? _____

Does/Did they have any health problems? Yes No

If yes, describe:

_____

Quality of relationship with them:

_____

5. Are your parent's: Married Divorced Separated Never Married Remarried

6. What was it like for you growing up in your family?

_____

_____

7. How was discipline handled in your family?

_____

_____

Current Family

1. What is your current marital status:

Married Divorced Never Married Separated Widowed Living Together

2. If applicable, how long have you been/were married?

_____

If applicable Name and age of spouse:_____

3. If applicable, how many times have you been married?

_____

4. If not married, are you in a relationship? Yes No

5. Do you have any children? Yes No
If yes, what are their ages? _____

6. Have family problems ever resulted in referral to County Children and Youth Services? Yes No

7. Who currently resides in your home?

_____

_____

8. If applicable, what is it like living in your current family or being in your current relationship?

_____

_____

Developmental History

1. Were there any problems prior to or during your birth that may have influenced your development? Yes No
If yes, specify:

_____

_____

2. Were there any problems during your infancy or childhood that may have influenced your development? Yes No
If yes, specify:

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_____
_____
_____

3. Have you ever had any history of physical, emotional or sexual abuse? Yes No
   If yes, specify:
   _____
   _____
4. Have you ever been witness to abuse Yes No
5. Have you had/have a partner who humiliates you or calls you names? Yes No
6. Have you had/have a partner that has been violent towards you? Yes No
7. Age of first sexual experience: _____
8. Sexual Orientation (circle one): Heterosexual Homosexual Bisexual Asexual
9. Do you have concerns regarding sexuality? Yes No
   If yes, explain:

_____
_____

Social History

1. What are your current hobbies or interests?

_____
_____

2. Are there any past hobbies or interests that you no longer are active in? Yes No
   If yes, what are they

_____
_____

Check how you generally get along with other people: (check all that apply)

___ Affectionate ___ Aggressive ___ Avoidant ____ Fight/Argue Often
___ Friendly ___ Leader ___ Outgoing ____ Shy/Withdrawn
___ Submissive ___ Other Specify: _____

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Educational History

1. What is your highest degree completed?
   Grade _____ High School Diploma GED Some College College Grad Post Grad
2. How did you do in elementary school? A's B's C's D's F's
3. If applicable, how did you do in high school? A's B's C's D's F's
4. If applicable, how did you do in college? A's B's C's D's F's
5. How well did you get along with your teachers at school? Good Fair Poor
6. Were there problem teachers? Yes No
   If yes, describe:
   _____
   _____
7. How well did you get along with the other students in your class? Good Fair Poor

   Were there any problems with peers? Yes No

   Were you ever teased or bullied? Yes No

   If yes, describe
   _____
   _____
8. Do you have any learning problems? Yes No
   If yes, describe:
   _____
   _____

   If yes, have you received treatment for them? Yes No

Employment History

1. What is your current employment status?
   Employed Unemployed Disabled Retired

   Other:_____

   If disabled, explain disability;

   _____

2. If employed, where are you employed?

_____

3. What is your position?

_____

4. How long have you been employed in your current position?

_____

5. How many jobs have you had in the past?

_____

6. What is the longest amount of time you have held a job?

_____

7. If no employed, list your job skills:

_____

Military History (please skip if not applicable)

1. What branch are/have you served?

_____

2. Have you ever served in combat? Yes No

3. What is your discharge status?

_____

Legal History

1. Are you currently involved in any legal proceedings? Yes No

2. Have you ever been arrested/charged/or incarcerated? Yes No

3. Are you currently on parole or probation? Probation Parole Neither

If so, who is your contact person?

_____

May we contact them? Yes No

If yes: ***complete the release of information form and include their name, address and phone number***

4. Do you have any past legal involvement? Yes No

Spiritual/Religious History

1. How important to you are spiritual matters? Not ___ Little ___ Moderate ___ Much___
2. Are you affiliated with a spiritual or religious group? Yes No
3. Were you raised within a spiritual or religious group? Yes No
4. Would you like your spiritual/religious beliefs incorporated into the counseling? Yes No

Cultural History

1. With what race/ethnicity do you identify?
   _____
2. Are there important aspects (beliefs/practices) of your culture that we need to be aware of that will affect how we provide treatment?
   Specify:

_____
_____
_____
_____

Treatment Goals

The changes I want to make are:

_____
_____

The most important reason I want to make these changes are:

_____
_____

Other people who could help me in changing are:

_____

_____

Ways they can help are:

_____

_____

The things that could stand in my way of making changes are:

_____

_____

My readiness for changes is best described as: (*circle the number that best describes how ready you are)*

1 2 3 4 5 6 7 8 9 10

Not Ready *Totally Ready*

My confidence that I can achieve my goals is:

(*Circle the percentage that best describes your confidence in achieving your goals)*

0% 25% 50% 75% 100%

Signature of Patient: _____

Date: _____

If Patient is unable to sign:

Patient Representative (Print Name): _____

Patient Representaive Signature: _____

Date: _____