Healing Relationships

Adult Intake Questionnaire

Your response to the following questions will enable your therapist to better understand you and your situation. Please answer all questions as completely as you can.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse/ Partner’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Partner Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Phone number where your therapist can leave you a detailed message? ( )** | | | | | | | | | | | |
| **Presenting Problem (current situation and history):** | | | | | | | | | | | |
| What are the primary problems for which you are seeking help? (please circle)   1. Marriage or relationship g. Problems with children m. Grieving 2. Family problems h. Peer problems n. Abuse or trauma 3. Depression i. Eating disorder o. Sexual functioning 4. Mood swings j. Alcohol/drug use p. Anger 5. Behavior k. Physical problems q. Anxiety or worry 6. Self-confidence l. Work related r. Other (explain): | | | | | | | | | | | |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How long have you lived with this/these problems? | | | | | |  | | | | |
| Have you received treatment for this problem or any other problem in the past? | | | | | | | | ☐ Yes ☐ No | | | |
| If yes when, where, and with whom? | | |  | | | | | | | | |
| Outcome of Treatment: 1 2 3 4 5 6 7 8 9 10  Much Worse Stayed the Same Much Better | | | | | | | | | | | |
| What did you find most useful? | | |  | | | | | | | | |
| What did you find least useful? | | |  | | | | | | | | |
| What is most concerning right now? | | |  | | | | | | | | |
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| **Family Past and Present** | |  | | | | |
| Current Family and Household Information | | | | |  | | | | | | |
| Name | | | | Relationship (parent, spouse, child, sibling) | | | | | Age | Gender | |
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| Length of current relationship if applicable? | | | | | | | |  | | | | | | | | | | | |
| Assessment of current relationship if applicable: | | | | | | | | | | Poor \_\_\_\_\_\_ Fair \_\_\_\_\_\_ Good \_\_\_\_\_\_ | | | | | | | | | |
| Do you have children from another relationship? | | | | | | | | | | | | | ☐ Yes ☐ No | | | | | | |
| If yes, give names and ages (unless already named above): | | | | | | | | | | | | | | | | | | | |
| What word would you use to describe your family of origin? | | | | | | | | | | | | |  | | | | | | |
| Were your parents always married or was there a divorce? | | | | | | | | | | | | |  | | | | | | |
| If they divorced, how old were you at the time? | | | | | | | | | | | | |  | | | | | | |
| How many siblings? And what is your birth order? | | | | | | | | | | | | |  | | | | | | |
| Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable. | | | | | | | | | | | | | | | | | | | |
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| Have you experienced any abuse in your adult life (physical, verbal, emotional, or sexual)? | | | | | | | | | | | | | | | | | | | |
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| Were drugs and alcohol a problem in your family when you were growing up? ☐ Yes ☐ No | | | | | | | | | | | | | | | | | | | |
| If yes, please explain: | | | |  | | | | | | | | | | | | | | | |
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| Please describe your alcohol consumption: | | | | | |  | | | | | | | | | | | | | |
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| Do you feel your alcohol consumption is problematic? ☐ Yes ☐ No | | | | | | | | | | | | | | | | | | |  |
| Have you ever felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No | | | | | | | | | | | | | | | | | | | |
| Have you ever had people annoy you by criticizing your drinking or drug use? ☐ Yes ☐ No | | | | | | | | | | | | | | | | | | | |
| Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No | | | | | | | | | | | | | | | | | | | |
| **Military:** | | | | | | | | | | | | | | | | | | | |
| Military Experience: | | | | | ☐ Yes ☐ No | | | | | | | Combat experience? | | | | | ☐ Yes ☐ No | | |
| Where |  | | | | | | | | | | | Branch: | | | | |  | | |
| Length of Service: | | |  | | | | | | | | | Type of discharge: | | | | |  | | |
| **Medical:** | | | | | | | | | | | |
| Have you had a physical exam to check for medical reasons for your symptoms? ☐ Yes ☐ No | | | | | | | | | | | | | | | | | | | |
| Do you have a psychiatrist? ☐ Yes ☐ No | | | | | | | | | | | Name of psychiatrist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| Have you had any major medical issues? | | | | | | | | | ☐ Yes ☐ No If yes, please list: | | | | | | | | | | |
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| Do you currently have any physical pain? | | | | | | | | | ☐ Yes ☐ No If yes, please explain: | | | | | | | | | | |
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| Is your pain constant or chronic (recurring or ongoing?) | | | | | | | | | | | | | | ☐ Yes ☐ No | | | | | |
| Please circle your pain level below:  0 1 2 3 4 5 6 7 8 9 10  No pain Mild pain Moderate pain Severe pain Extreme pain As bad as  it could be | | | | | | | | | | | | | | | | | | | |
| Medication | | Dosage/Frequency | | | | | Prescribing Physician | | | | | | | | | For what condition? | | Taking as Prescribed? | |
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| Do your family or friends have concerns about your lifestyle or eating habits? | | | | | | | | | | | | | | | | | | ☐ Yes ☐ No | |
| **Goals:** | | | | | | |
| What goals would you like to see reached as a result of counseling? | | | | | | | | | | | | | | | | | | | |
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| What would let you know those goals have been reached? | | | | | | | | | | | | | | |  | | | | |
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| What strengths or resources do you have that will help you succeed in counseling? (Examples: commitment, strong family support, intelligence, good social support, church, friends, etc) | | | | | | | | | | | | | | | | | | | |
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| What might prevent your success in counseling? (Examples: few friends, financial stress, lack of social support, lack of family support, etc.) | | | | | | | | | | | | | | | | | | | |
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