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Adult Intake Questionnaire

Client Name:_____ Date: _____ Age: _____

Ethnicity/Race: _____ Gender: _____male, _____female

Marital Status: _____single, _____married, _____separated, _____divorced, _____widow

Present Concerns: _____

_____

_____

Allergies: no____, yes____ If so, what_____

Medical Concerns: no____, yes____ If so, what_____

_____

Current Medications/Doses: _____

_____

Symptom Checklist (please check next to any items that fit for you)

Depressive/Mood Symptoms

_____Feeling sad or empty
_____Decreased interest in Activities
_____feel restless or slowed down
_____fatigue/loss of energy
_____feelings of worthlessness
_____Difficulty concentrating, Indecisive
_____Feelings of hopelessness
_____Mood swings
_____more talkative
_____Flight of ideas, racing Thoughts
_____Excessive engagement in pleasurable activities (shopping sprees, sexual indiscretions, risky business ventures)

Sleep difficulties

_____Hard to fall asleep
_____Hard to stay asleep
_____Early morning awakenings
_____Decreased need for sleep

Anxiety Symptoms

_____Feels of worry
_____Feel restless or on edge
_____Irritability
_____Muscle tension
_____Compulsive/repetitious Behaviors
_____Obsessive thoughts

Weight/Diet

_____Significant weight loss
_____Significant weight gain
_____Poor appetite
_____Overeating
_____Binging food
_____Vomiting after eating
_____Worries/fear about gaining weight
_____Use of laxitives

Attention Symptoms

_____Inattention
_____Hyperactivity
_____Impulsivity

Panic Symptoms

_____Heart racing
_____Sweating
_____trembling/shaking
_____Shortness of breath
_____Feeling of choking
_____Chest Pain
_____Nausea
_____Dizziness
_____Feeling detached
_____Fear losing control or going crazy
_____Fear of dying
_____Numbness/tingling
_____Chills or hot flashes
_____Fear of leaving home

Other Symptoms

_____Memory loss
_____Difficulty controlling anger
_____Concerns about sex
_____Sexual identity concerns

Ever tried to hurt yourself? no____, yes____
Current thoughts to hurt yourself? no____, yes____
Current plan to hurt yourself? no____, yes____

Ever tried to hurt someone else? no____, yes____
Current thoughts to hurt someone else? no____, yes____
Current plan to hurt someone else? no____, yes____

History of abuse? no____, yes____
Ever been touched in a way that made you feel uncomfortable? no____, yes____
Are you dealing with a past or current trauma? no____, yes____

Ever see or hear things that other people don't? no____, yes____

Relationship concerns? no____, yes____ If so, what? _____

_____

History of alcohol abuse? no____, yes____
Do you currently drink alcohol? no____, yes____ If so, how much per week? _____

History of drug abuse? no____, yes____
Do you currently use drugs? no____, yes____ If so, how much per week? _____

Any past counseling experiences? no____, yes____ If so, what? _____

_____

Family history of mental illness? no____, yes____ If so, what? _____

_____

What you would like to get out of therapy 1)_____

2)_____

3)_____

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