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ADULT INFORMATION QUESTIONNAIRE

Welcome to our office. Please complete the following questionnaire which will be helpful in planning our services for you. If you need clarification on any question please do not hesitate to call or ask at time of session.

CLIENT INFORMATION

Full Name: _____ Today's Date_____

Address: _____

City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Age: _____ Birth Date: _____

Occupation/Job Title: _____

Employer/School: _____

Relationship Status (circle one):

Single Married/Partnered Separated/Divorced Widowed

Length of current relationship: _____

Spouse/Partner's Name: _____

Spouse/Partner's Employer:_____

Insurance Information (You will need your card at first session):

Insurance Company: _____

Insurance Phone Number(Back of Card): _____

Subscriber ID#: _____Group#:_____

Primary Subscriber: _____ Copay: Yes / No Amount:_____

Primary Subscriber DOB: _____

Your Education: _____

Religious Preference: _____

List members of your family and all others <u>living in your home:</u>

Name	Age	Relationship	Occupation

Who Suggested you contact us?: _____

Would it be permissible to thank them?: ☐ yes ☐ no Please initial: _____

Their Address: _____

Name of person to contact in case of an emergency: _____

Address: _____ Phone: _____

Have you ever received psychiatric or psychological help of any kind before? ☐ yes ☐ no

Therapist	Dates	Purpose	Was it helpful?
			☐ yes ☐ no
			☐ yes ☐ no
			☐ yes ☐ no
			☐ yes ☐ no

Who is your primary physician? _____

Date of your last physical? _____

Address: _____

Phone: _____ Fax: _____

It is our policy to inform your physician that you are receiving counseling. This is for the purpose of coordinating treatment. May I notify your physician about the issues for which you are seeking counseling? ☐ yes ☐ no Please initial: _____

List major health concerns for which you are currently receiving treatment:

_____

_____

_____

Allergies or adverse reactions to medication or treatment: _____

List any medications you are currently taking:

Name of medication	Dosage	Frequency	Prescribed by	Start Date

Briefly describe your reason for seeking help: _____

Any other concerns or questions that we can address together in session?:

Current Symptoms

Please **circle the number** to rate the following symptoms according to the degree to which they are troubling your current life. Also, **in the blank**, indicate **how long** these problems have affected you.

Scale: **6= Extremely, big problem** **1= Little or no concern**

MOOD 1 2 3 4 5 6 _____
Tiredness 1 2 3 4 5 6 _____
Inferiority Feelings 1 2 3 4 5 6 _____
Concentration 1 2 3 4 5 6 _____

Hurting others 1 2 3 4 5 6 _____
Hurting Self 1 2 3 4 5 6 _____
Food Management 1 2 3 4 5 6 ___
Dangerous behavior 1 2 3 4 5 6 __

Appetite: 1 2 3 4 5 6 _____
Weight Gain/Loss 1 2 3 4 5 6 _____
Attention Deficit 1 2 3 4 5 6 _____
SUBSTANCE USE 1 2 3 4 5 6 ____
Amount in last month: _____
Alcohol 1 2 3 4 5 6 _____
Drinks/week _____
Drugs 1 2 3 4 5 6 _____
Name/amount _____
Caffeine 1 2 3 4 5 6 _____
Drinks/week _____
Tobacco 1 2 3 4 5 6 _____
Packs/week _____
Sleep 1 2 3 4 5 6 _____
Nightmares 1 2 3 4 5 6 _____
Insomnia 1 2 3 4 5 6 _____
Ambition 1 2 3 4 5 6 _____
Unhappiness 1 2 3 4 5 6 _____
Irritability 1 2 3 4 5 6 _____
Depression 1 2 3 4 5 6 _____
Manic Behavior 1 2 3 4 5 6 _____
Suicidal Thoughts 1 2 3 4 5 6 _____
ANXIETY 1 2 3 4 5 6 _____
Nervousness 1 2 3 4 5 6 _____
Panic Attacks 1 2 3 4 5 6 _____
Compulsive Behavior 1 2 3 4 5 6 _____
Obsessive Behavior 1 2 3 4 5 6 _____
Fears 1 2 3 4 5 6 _____
HEALTH 1 2 3 4 5 6 _____
Bowel Troubles 1 2 3 4 5 6 _____
Headaches 1 2 3 4 5 6 _____
Stomach Trouble 1 2 3 4 5 6 _____
Binging/Purging 1 2 3 4 5 6 _____
THOUGHTS 1 2 3 4 5 6 _____
Making Decisions 1 2 3 4 5 6 _____
Confusion 1 2 3 4 5 6 _____
Communicating 1 2 3 4 5 6 _____
IMPULSE CONTROL 1 2 3 4 5 6 _____
Anger 1 2 3 4 5 6 _____
Temper 1 2 3 4 5 6 _____
RELATIONSHIPS 1 2 3 4 5 6 ____
Friends 1 2 3 4 5 6 _____
Marriage 1 2 3 4 5 6 _____
Separation/Divorce 1 2 3 4 5 6 ___
Children 1 2 3 4 5 6 _____
Shyness 1 2 3 4 5 6 _____
Loneliness 1 2 3 4 5 6 _____
Fear of being alone 1 2 3 4 5 6 ___
Distancing others 1 2 3 4 5 6 ____
Sexual problems 1 2 3 4 5 6 _____
SELF CARE 1 2 3 4 5 6 _____
Work 1 2 3 4 5 6 _____
Career Choices 1 2 3 4 5 6 _____
Education 1 2 3 4 5 6 _____
Legal Matters 1 2 3 4 5 6 _____
Finances 1 2 3 4 5 6 _____
Stress 1 2 3 4 5 6 _____
ABUSE 1 2 3 4 5 6 _____
Physical 1 2 3 4 5 6 _____
Sexual 1 2 3 4 5 6 _____
Emotional 1 2 3 4 5 6 _____

List any other concerns you may have at this time: _____
_____
_____
_____
_____

Optional Questions

What do you do for relaxation and enjoyment? _____
_____
_____

How much attention do you pay to your physical health? Please explain. _____
_____
_____

How does spirituality inform or assist you in managing your life? _____
_____
_____

What do you value most in life? _____
_____
_____

How important is honesty in your life? Please explain. _____
_____
_____

How many hours each week is the television on in your home? _____
How many hours each week are you on the computer? _____
How many hours each week do you play video games? _____

What are your likes or dislikes about the television, computer, and/or videogames? _____
_____
_____
_____
_____
_____

If everything were better in your life, what would that look like? _____
_____
_____
_____
_____