ADULT INTAKE QUESTIONNAIRE

Date Completed:

I. IDENTIFYING INFORMATION

Name:					
DOB / Age:	/				
Street Address: City, State, Zip Code: Telephone:	Home: - - Mobile: - -	Occupation: Employer			
Race/Ethnicity:		Sex:	Male ☐ / Female ☐		
Spouse: Street Address: City, State, Zip Code: Telephone:	Home: - - Mobile: - -	DOB / Age: Occupation: Employer	/		
Children:		Age:		Sex:	-
					-
					-
					-
Who Referred you?:					
Caseworker:					
Funding Source:	☐ Private Pay				
	☐ Insurance				
Primary Insurance: Name of Subscriber: Employer: Policy Number: Group Number:					
Emergency Contact: Telephone:	Home: - - Mobile - -				

Connections Family Counseling, LLC
8th & State Plaza # 9
Quincy, IL 62301
217-231-1413

II. PROBLEM IDENTIFICATION

What is the presenting problem and/or the reason for seeking support at this time?

When Did the Problems Begin?

Are There Identifiable Triggers (things that may have caused or exacerbated the problem)?

How Have These Problems Impacted Family Functioning?

III. FAMILY SOCIAL INFORMATON

Please Describe Your Current Family Function and/or Status

Please List History of Geographical Relocation(s)

Dates	Location	Reason for moving

Please List Family History of Mental Health Issues

Family Member	Mental Health Issue	Treatment	Response

Please List Family History of Substance Abuse: -

IV. CLIENT SPECIFIC INFORMATION

Legal History

- Current Legal Issues/Concerns:

- Past Legal Concerns:

Lifestyle Issues

- Please describe your social relationships:

- What are your hobbies/interests?

- Do you currently participate in any church or community activities?

- What are your strengths?

- What are your limitations?

- Describe your support network:

Marital Issues

- How would you describe your marriage?

- What strengths do you and your spouse bring to the marriage relationship?

  Your strengths:

  Your Spouse:

- What growth areas do you and your spouse bring to the marriage relationship?

  Your growth areas:

  Your Spouse:

- What is the most important thing you need from your spouse that you may or may or not be getting?

- What is the most important thing that your spouse needs from you that he/she may not be getting?
- Have you or your spouse been married before?

- Do you or your spouse have children from a previous relationship?

<u>Parenting Issues</u>

- How would you describe your parenting style?

- How would you describe your spouse' parenting style?

- What has worked well in your parenting?

- What challenges do you face in this area?

- What is one area that you would like to see different in your relationship to your children?

Employment Issues

- Please list any problems with employment?

Spirituality:

- Would you describe spirituality as an important part of your life?

- Are you or have you been involved in any place of worship?

- What is your religious affiliation?

- Would you prefer that issues of faith are a part of counseling services ☐ Yes ☐ No

V. TRAUMA HISTORY

Please Check All Trauma Types You Have Experienced and Then Provide Additional Information:

Sexual Maltreatment / Abuse / Rape: ☐

Physical Maltreatment / Abuse / Assault: ☐

Emotional Abuse / Psychological Maltreatment: ☐

Neglect: ☐

Domestic Violence: ☐

War / Terrorism: ☐

Medical Trauma / Illness: ☐

Serious Injury / Accident: ☐

Natural Disaster: ☐

Kidnapping: ☐-

Traumatic Loss / Bereavement: ☐

Extreme Interpersonal Violence: ☐

Community Violence: ☐

School Violence: ☐

Forced Displacement: ☐

Impaired Caregiver: ☐

Other Significant Events or Traumas: ☐

VI. HISTORY OF MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT

Have you ever been seen by a counselor/therapist, psychologist, or psychiatrist? ☐ Yes ☐ No

Dates of Treatment	Facility & Location	Reason for Treatment	Doctor/ Therapist	Diagnosis

Please List Past Medications

Medication	Dosage & Frequency	Target Symptoms	Doctor

Please List Current Medications

Medication	Dosage & Frequency	Target Symptoms	Doctor

Please List Current Illness or Conditions

Illness/Condition	Date Began to Date Ended	Medications	Doctor

Have You Undergone Treatment for Substance Abuse: Yes ☐ No ☐ If yes, location:

History of Substance Abuse:				
Substance:	Quantity	Frequency	Age Began	Duration
Tobacco				
Alcohol				
Marijuana				
Other				
Addictive Beh.				

Female Clients Only: Are You Currently Pregnant? ☐ Yes / ☐ No / ☐ N/A

VII. PLEASE IDENTIFY CURRENT / PAST SYMPTOMS (place an “X” in appropriate boxes

Symptoms	Current	Past	None	Symptoms	Current	Past	None
Mood Changes	☐	☐	☐	Mania	☐	☐	☐
Sleep Disturbance	☐	☐	☐	Grandiosity	☐	☐	☐
Appetite or Weight Change	☐	☐	☐	Pressured Speech	☐	☐	☐
Crying	☐	☐	☐	Distractibility	☐	☐	☐
Irritability	☐	☐	☐	Racing Thoughts	☐	☐	☐
Loss of Interests	☐	☐	☐	Hypersexuality	☐	☐	☐
Withdrawal	☐	☐	☐	↑ Goal Directed Beh.	☐	☐	☐
Energy Level Change	☐	☐	☐	↑ Pleasure Activity	☐	☐	☐
Memory Difficulties	☐	☐	☐	Decreased Sleep	☐	☐	☐
Low Self-Esteem	☐	☐	☐				
Helplessness	☐	☐	☐	Hyperactivity	☐	☐	☐
Hopelessness	☐	☐	☐	Impulsivity	☐	☐	☐
Somatization (aches, pains)	☐	☐	☐	Inattentive	☐	☐	☐
	☐	☐	☐	Easily Distracted	☐	☐	☐
Hypervigilance (always alert)	☐	☐	☐	Fidgets	☐	☐	☐
Re-experiencing an event	☐	☐	☐	Cant Follow Instruction	☐	☐	☐
Intrusive Thoughts	☐	☐	☐	Losses Things	☐	☐	☐
Flashbacks of an event	☐	☐	☐				
Nightmares	☐	☐	☐	Panic Attacks	☐	☐	☐
Checking out (dissociation)	☐	☐	☐	Excessive Anxiety	☐	☐	☐
Numbing	☐	☐	☐	Heart Palpitations	☐	☐	☐
Inability to remember trauma	☐	☐	☐	Persistent Fear	☐	☐	☐
Avoidance	☐	☐	☐	Trembling	☐	☐	☐
	☐	☐	☐	Sweating	☐	☐	☐
Physical Aggression	☐	☐	☐	Short of Breath	☐	☐	☐
Verbal Aggression	☐	☐	☐	Excessive Worry	☐	☐	☐
Oppositional Stances	☐	☐	☐		☐	☐	☐
Rule Violation	☐	☐	☐	Obsessions	☐	☐	☐
Property Destruction	☐	☐	☐	Compulsions	☐	☐	☐
Bullying	☐	☐	☐		☐	☐	☐
Lying	☐	☐	☐	Self-Mutilation/injury	☐	☐	☐
Theft	☐	☐	☐		☐	☐	☐
Temper Tantrums	☐	☐	☐	Delusions	☐	☐	☐
Disrespect	☐	☐	☐	Hallucinations	☐	☐	☐
	☐	☐	☐	Disorganized Speech	☐	☐	☐
Poor Eye Contact	☐	☐	☐	Disorganized Behavior	☐	☐	☐
Indiscriminate Affection	☐	☐	☐		☐	☐	☐
High Control Need	☐	☐	☐	Misses Social Cues	☐	☐	☐
Resists Comfort / Closeness	☐	☐	☐	Poor Peer Relations	☐	☐	☐
Food Issues	☐	☐	☐	Lack of Reciprocity	☐	☐	☐
Superficially Charming	☐	☐	☐	Inflexible	☐	☐	☐
Lack of Empathy for Others	☐	☐	☐	Repetitive Motor	☐	☐	☐
Poor Cause and Effect	☐	☐	☐	Significant. Preoccupation	☐	☐	☐
Lacks Enjoyment with Others	☐	☐	☐	Language Delays	☐	☐	☐
Suicidal Thoughts	☐	☐	☐	Homicidal Thoughts	☐	☐	☐
Suicide Plans	☐	☐	☐	Homicidal Threats	☐	☐	☐
Attempts/Gestures	☐	☐	☐	Homicidal Plans	☐	☐	☐
Hospitalization	- Times			Hospitalization	- Times		

Are You Aware of Any Current Mental Health Diagnosis?

What Are Your Goals for Counseling Services?

Is There Any Additional Information that Your Therapist Should Know: