Intake Questionnaire For Adults

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All information that you provide us will be confidential as required by state and federal law.

Date: _____ **Medicaid ID Number:** _____

Name: _____ **Date of Birth:** _____ **Gender: M F Non-binary (Circle all that apply)**

Address: _____ **City/State/Zip Code:** _____

Phone: _____ **Cell Phone:** _____

Email: _____ **Home Phone:** _____

◯ Foster ◯ Post-Adopt ◯ Non-Medicaid ◯ DWS ◯ WHS ◯ 295

◯ Self Pay ◯ Insurance ◯ MI-706 ◯ JJS

If you checked "Insurance" above, please fill out the insurance box(es) below:

Primary Insurance: _____ Policy Holder Name: _____

Policy Holder DOB: _____ Relationship to you: _____

Policy Holder Address: _____ Policy Number: _____

Seconday Insurance: _____ Policy Holder Name: _____

Policy Holder DOB: _____ Relationship to you: _____

Policy Holder Address: _____ Policy Number: _____

Marital Status: (Circle) ◯ single ◯ married ◯ separated ◯ divorced ◯ other ◯ remarried ◯ engaged ◯ widowed ◯ cohabiting

If applicable, please complete the following:

Partner's Name: _____ **Partner's Age:** _____

Partner's Occupation: _____

Emergency Contact Name (If different than partner listed above)

Name: _____ Phone: _____

Relation to Client: _____

IF YOU HAVE CHILDREN, PLEASE LIST THEIR NAMES AND AGES:

#	Name	Sex	Age	#	Name	Sex	Age
1				4			
2				5			
3				6			

WHO CURRENTLY LIVES IN YOUR RESIDENCE (adults and children):

#	Name	Relation	Sex	Age	#	Name	Relation	Sex	Age
1					4				

2					5				
3					6				

In your own words, describe the current problems as you see them:

How long has this been going on?

What made you come in at this time?

What do you hope to gain from this evaluation and/or counseling?

If you had difficulties in the past, what have you done to cope? Was it helpful?

Symptoms

Please **check** any sypmtoms or experiences that you have had **in the last month**

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Difficulty getting out of bed
- ☐ Not feeling rested in the morning

Average hours of sleep per night: _____

- ☐ Persistent loss of interest in previously enjoyed activities
- ☐ Withdrawing from other people
- ☐ Depressed Mood
- ☐ Rapid mood changes
- ☐ Anxiety
- ☐ Frequent feelings of guilt
- ☐ Difficulty leaving your home
- ☐ Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: _____
- ☐ Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)
- ☐ Outbursts of anger

- ☐ Worthlessness
- ☐ Hopelessness
- ☐ Sadness
- ☐ Helplessness
- ☐ Fear
- ☐ Feeling or acting like a different person

- ☐ Changes in eating/appetite
- ☐ Eating more
- ☐ Eating less
- ☐ Voluntary vomiting
- ☐ Use of laxatives
- ☐ Excessive exercise to avoid weight gain
- ☐ Binge eating
- ☐ Are you trying to lose weight? _____

Weight gain: lbs Weight loss: lbs

☐ Difficulty catching your breath
☐ Unusual sweating
☐ Increased energy
☐ Tremor
☐ Frequent worry
☐ Racing thoughts
☐ Increased muscle tension
☐ Easily started, feeling "jumpy"
☐ Decreased energy
☐ Dizziness
☐ Physical sensations others don't have
☐ Intrusive memories

☐ Difficulty concentrating or thinking
☐ Flashbacks
☐ Thoughts about harming or killing yourself
☐ Large gaps in memroy
☐ Nightmares
☐ Thoughts about harming or killing someone else

☐ Feeling as if you were outside yourself, detached, observing what you are doing
☐ Feeling puzzled as to what is real and unreal
☐ Persisten, repetitive, intrusive thoughts, impulses, or images
☐ Unusual visual experiences such as flashes of light, shadows
☐ Hear voices when no one is present
☐ Feeling that your thouths are controlled or placed in your mind
☐ Feeling that the television or the radio is communicatiing with you

☐ Difficulty problem solving
☐ Dependency on others
☐ Inappropriate expression of anger
☐ Difficulty or inability to say "no" to others
☐ Sense of lack of control
☐ Abusive relationship
☐ Concerns about your sexuality
☐ Difficulty meeting role expectations
☐ Manipulation of others to fulfill your own desires
☐ Self-mutiliation/cutting
☐ Ineffective communication
☐ Decreased ability to handle stress
☐ Difficulty expressing emotions

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other ☐ I prefer not to say

Please describe any other symptoms or experiences you have had problems with:

_____

_____

_____

Have you seen a counselor, psychologist, psychiatrist or other mental health professional before?

☐ No ☐ Yes If so:

Name of Therapist: _____ Dates of Treatment: _____

Reason for seeking help: _____ _____

Are you **CURRENTLY** taking **PSYCHIATRIC** medication? ☐ No ☐ Yes If YES, please list:

Medication	Dosage	Been taking it how long?	Has it been helpful?

Are you **CURRENTLY** taking NON-**PSYCHIATRIC** medication? ☐No ☐Yes If YES, please list:

Medication	Dosage	Been taking it how long?	Has it been helpful?

Have you been on **PSYCHIATRIC** medication in the past? ☐No ☐Yes If YES, please list:

Medication	Dosage	First/last time you took it	Effect of Medicaton

Have you been hospitalized for psychiatric reasons? ☐No ☐Yes If YES, please list:

Hospital	Dates	Reason

Have you ever attempted suicide? ☐No ☐Yes If YES, describe: _____

MEDICAL HISTORY

Are you **CURRENTLY** under treatment for any medical condition(s)? ☐No ☐Yes If YES, please list:

List any PRIOR illnesses, operations, and accidents:

FAMILY HISTORY

Father: Age: _____ ☐Living ☐Deceased Cause of death: _____
If deceased, HIS age at time of his death: _____ YOUR age at time of his death: _____
Occupation: _____ Health: _____
Frequency of contact with him: _____ Are you/Have you been close to him? _____

Mother: Age: _____ ☐Living ☐Deceased Cause of death: _____
If deceased, HER age at time of her death: _____ YOUR age at time of her death: _____
Occupation: _____ Health: _____
Frequency of contact with her: _____ Are you/Have you been close to her? _____

Brothers and Sisters

Name	Gender	Age	Whereabouts	Are you close to him/her?	
				No	**Yes**
				No	**Yes**
				No	**Yes**
				No	**Yes**
				No	**Yes**
				No	**Yes**

During your childhood, did you live any significant period of time with anyone other than your natural parents?

☐No ☐Yes If so, please give the person's name and relationship to you:

Name: _____ Relationship to you: _____

Please place a check mark in the appropriate box if these are or have been present in your relatives.

	Brothers	Sisters	Father	Mother	Uncle/Aunt	Grandparents
Nervous Problems						
Depression						
Hyperactivity						
Counseling						
Psychiatric Hospitalization						
Suicide Attempt						
Death by Suicide						
Drinking Problem						

SOCIAL HISTORY

Past Marital History

Have you been married previously? _____ If Yes, please describe:

When? _____ How long? _____

When? _____ How long? _____

Education

Highest grade level completed: _____

Highest degree obtained, if applicable: _____

Have you had any disciplinary problems in school? _____

If yes, please explain: _____

Were you considered hyperactive/ADHD in school? _____

If yes, were/are you on any medication? _____ If so, which medication? _____

What kind of grades did you get in school? _____

Have you served in the military? _____ If Yes, please describe briefly: _____

_____

What type of discharge (separation) did you get? _____

Employment

Are you currently employed? _____ If yes, employer's name: _____

What type of work do you do? _____

Employment History (most recent first)

Type of Job	Dates	Reason for Leaving

General

Have you ever been arrested? _____

If yes, please describe: _____

Do you have a religious affiliation? _____ If so, what is it? _____

What kind of social activities do you participate in? _____

_____

Who do you turn to for help with your problems? _____

Have you ever been abused?

☐ Verbally ☐ Emotionally ☐ Physically ☐ Sexually ☐ Neglected

Please describe: _____

_____

_____

_____

_____

_____

SUBSTANCE ABUSE

Alcohol

Do you drink alcohol? _____ If yes, age of first use: _____

How much do you drink? _____

How often do you drink? _____

Do you use tobacco (cigarettes, dip)? _____ If yes, how often? _____

Do you vape? _____ If yes, how often? _____

Other drugs: Please indicate for each drug listed below.

Drug	Ever used	Age at 1st use	Time since last use	Approx use in last 30 days
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				

Is there anything else you would like us to know about you?