ADULT INTAKE QUESTIONNAIRE

Please fill in the information below and bring it with you to your first session.

INFORMATION PROVIDED ON THIS FORM IS PROTECTED AS CONFIDENTIAL INFORMATION

DATE:_____

CLIENT NAME:_____ PREFERRED NAME:_____
CLIENT DATE OF BIRTH_____ AGE:_____ GENDER_____

PHONE _____ Is it OK to leave a message**?** YES NO Is it OK to text**?** YES NO

SECONDARY PHONE _____ Is it OK to leave a message**?** YES NO Is it OK to text**?** YES NO

STREET ADDRESS_____
CITY, STATE, ZIP _____

******If you are a college student, please list your current address at school if not indicated to the left.***
STREET ADDRESS_____
CITY, STATE, ZIP _____

E-MAIL _____ Is it OK to send a message**?** YES NO

E-mail is not used to communicate protected health information, as e-mail is not considered to be a confidential form of communication

HOW DID YOU HEAR OF DAWN? Insurance Website Psychology Today Dr. Paturi ISU Student Health
IWU Student Health Primary Care Provider_____ Friend/Family_____ OTHER_____

TREATMENT HISTORY

1) Have you previously received any type of outpatient mental health services (psychotherapy, psychiatric services, etc.)? YES NO
Previous therapist/practitioner_____ Dates_____

2) Are you currently taking any prescription medication for mood/anxiety/focus management? YES NO
If yes, please list
Medication_____ Dosage_____ Managing Practitioner _____
Medication_____ Dosage_____ Managing Practitioner _____
Medication_____ Dosage_____ Managing Practitioner _____

3) Have you ever been prescribed medication for mood/anxiety/focus management? YES NO
If yes, please list
Medication_____ Reason_____ When_____
Medication_____ Reason_____ When_____
Medication_____ Reason_____ When_____

4) Have you ever been hospitalized or received inpatient treatment for mental health or substance abuse? YES NO
If yes, please list
Reason_____ Dates (approx.)_____ Location_____
Reason_____ Dates (approx.)_____ Location_____
Reason_____ Dates (approx.)_____ Location_____

GENERAL AND MENTAL HEALTH HISTORY

5) How would you rate your current physical health?
Poor Fair Good Excellent
Please list any specific health problems you are currently experiencing _____

6) Have you ever had any major illnesses, injuries, medical treatments, or surgeries which still affect you today either physically or psychologically? YES NO
If so, please explain_____ _____

7) Are you currently experiencing any chronic illness or pain? YES NO
If yes, please describe: _____
If yes, have you been issued a Medical Cannabis Registry Card related to your illness or pain? YES NO
If yes, who is the certifying physician? _____

GENERAL AND MENTAL HEALTH HISTORY (continued)

8) Are you currently experiencing any difficulties or problems with your appetite or eating? YES NO
If yes, please describe: _____
Did you ever have an eating disorder which is now in remission? YES NO

9) How would you rate your current sleep?
Poor Fair Good Excellent
Please list any specific sleep problems you are currently experiencing_____
How many hours of sleep do you get each night? _____

10) How frequently do you exercise? _____ Type?_____

11) Do you drink alcohol? YES NO
If yes, Type_____ Frequency_____ Amount_____

12) Do you engage in recreational drug use? Daily Weekly Monthly Infrequently Never

13) Over the last 2 weeks, how often have you been bothered by the following problems?	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERYDAY
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it's hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling/staying asleep, sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things such as reading the newspaper or watching television.	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Engaging in impulsive behaviors, such as spending, sex, etc	0	1	2	3
Outbursts of anger or aggression	0	1	2	3
Feeling refreshed or alert with little or no sleep	0	1	2	3
Difficulty controlling crying or being overly tearful	0	1	2	3
Neglecting housework or hygiene due to lack of motivation	0	1	2	3

14) To the best of your knowledge, has anyone in your immediate family ever experienced the following mental health/developmental issues whether they were diagnosed or suspected?		Relationship to you
Anger/Impulse Control Problems	YES NO	
Major Depression	YES NO	
Anxiety Disorders (include OCD, panic, and phobias as well)	YES NO	
Bipolar Disorder	YES NO	
Pervasive Developmental Disorders (e.g. Autism, Asperger's)	YES NO	
Alcohol/Substance Abuse	YES NO	
Schizophrenia/Psychosis	YES NO	
Has anyone close to you committed suicide?	YES NO	

SOCIAL HISTORY

15) With whom do you live (circle all that apply): live alone mother father step-parent sibling(s) #____
husband wife boyfriend girlfriend minor child(ren) #____
adult child(ren) #____ roommate(s)#____ other_____

16) If applicable, please answer: Years with current partner/spouse _____ # of children from relationship _____
Previous significant relationships: Years with former partner/spouse_____ # of children from relationship _____
Years with former partner/spouse _____ # of children from relationship _____

17) Do you feel *unsafe* in your home? YES NO

18) How would you rate the quality of your current support network and friendships?
Poor Fair Good Excellent

19) Are you active in hobbies, activities or interests? YES NO Type_____

20) Do you consider yourself to be spiritual or religious? YES NO
If yes, describe your faith or belief _____

21) Education:
CURRENT HIGH SCHOOL STUDENTS: School attending_____ Grade_____
How are you doing? *Academically:* Excellent OK Struggling *If summer, grade recently completed*
Socially: Excellent OK Struggling
Attendance: Excellent OK Struggling
If you have an IEP/504 plan, please list accomodations_____
CURRENT COLLEGE STUDENTS: School attending_____ Level_____
How are you doing? *Academically:* Excellent OK Struggling
Socially: Excellent OK Struggling
Attendance: Excellent OK Struggling
Current Major_____
IF GRADUATED/NOT IN SCHOOL:
Highest level of education completed: HS Diploma GED Associates Trade Certificate Bachelors Masters Doctorate
Degree(s) Held:_____

22) Are you currently employed? YES NO
If yes, employment status: Full time Part time (#hours per week_____)
Employer_____ Occupation/Position_____
On a scale of 1 to 10 (with 10 being a very satisfied), please rate your level of job satisfaction? _____
On a scale of 1 to 10 (with 10 being a very secure), please rate your feeling of job security? _____
On a scale of 1 to 10 (with 10 being a very high amount), please rate the amount of stress in your job currently? _____

23) If not employed, are you (circle all that apply)
Still in school Looking for work Raising children/running household Retired On Disability/unable to work
Primary caregiver for_____

24) Have you experienced any significant losses, life changes or stressors in the past year? YES NO
If yes, please explain _____
_____

25) Have you ever been the victim of abuse either as a child or adult (include physical, verbal, emotional, sexual, domestic violence, or neglect as a child)? YES NO

26) By your definition, have you ever experienced a traumatic event or situation that you felt was life changing or still affects you today which was not indicated above? YES NO
If yes, please explain _____
_____

27) Do you have any current or pending legal issues (e.g. DUI, criminal, child custody, divorce, lawsuit, bankruptcy)? YES NO
If yes, please explain _____

ADDDITIONAL INFORMATION

28) What do you consider to be some of your strengths?_____
_____

29) What do you consider to be some of your weaknesses? _____
_____

30) What made you seek out counseling at this time? _____
_____

31) What issues would you like to address in counseling? _____
_____
_____
_____
_____

32) Please share any additional information that you feel would be helpful for Dawn to know to best help you? _____
_____
_____
_____
_____

Thank you for taking the time to complete this form!