

Adult Intake Questionnaire

Background Information

1. Preferred name to be called/Nickname: _____
2. Gender Identity (circle): Male, Female, Other, specify: _____
3. Marital Status (circle): never married, partnered, married, separated, divorced, or widowed
4. Is it OK to leave voice messages on any of the following phone numbers?
(Check all that apply and write in):
 - a. Home #: _____
 - b. Work #: _____
 - c. Cell #: _____
 - d. Other #: _____
5. Ethnic Identity: _____
6. Religious/Spiritual Preference(s): _____
7. Why are you seeking psychotherapy at this time? _____

8. How would you currently rate the problem(s) you are seeking help with at this time?
Use a scale from 1 to 5; 1=not intense and 5 = extremely intense _____
9. How long has the current problem(s) been occurring? _____
10. Please list your current coping strategies in dealing with the problem(s): _____

11. Are you currently receiving other mental health services, counseling or psychotherapy elsewhere?
Yes No (circle one)
If **yes**, what services, where and how often? _____

12. Have you ever received counseling or therapy before? **Yes No** (circle one)
If **yes**, for what purposes? _____

What services were helpful and why? _____

What services were unhelpful and why? _____

Mental Health

1. Are you currently experiencing any suicidal thoughts?
Circle one: frequently, sometimes, rarely, never
2. Have you ever experienced suicidal thoughts?
Circle one: frequently, sometimes, rarely, never
3. Have you ever intentionally inflicted any harm on yourself? **Yes No** (circle one)
If **yes**, please explain: _____

4. Have you ever intentionally inflicted any harm on someone else? **Yes No** (circle one)
If **yes**, please explain: _____

5. Have you ever been hospitalized for mental health issues? **Yes No** (circle one)
If **yes**, please provide when, where and reason: _____

Physical Health

1. How would you rate you current physical health? _____

2. Have you ever been hospitalized for a physical condition? **Yes No** (circle one)
If **yes**, please provide when, where and reason: _____

3. So you have any difficulties with sleep? **Yes No** (circle one)
If **yes**, what and how often? _____

4. Any recent appetite or eating changes? **Yes No** (circle one)
If **yes**, circle **any** that may apply: weight gain, weight loss, food restriction, bingeing, eating more, eating less

And, please explain: _____

5. Do you exercise? **Yes No** (circle one)
If **yes**, what is the duration (in minutes/hours) of your typical exercise session? _____

How many times per week? _____

6. Do you have any problems or worries about sexual functioning? **Yes No** (circle one)
If **yes**, please explain: _____

Substance Use

1. Do you smoke? **Yes No** (circle one)
If **yes**, how much and how often? _____

2. Do you currently drink alcohol? **Yes No** (circle one)
If **yes**, how many drinks per week on average to you consume? _____

3. Has anyone in your family currently have or has had in the past a substance abuse problem and/or an alcohol abuse problem? **Yes No** (circle one)
If **yes**, please explain: _____

4. Are you currently taking any prescribed psychiatric medication(s)? **Yes No** (circle one)
If **yes**, please list medication(s) and dosage: _____

5. Have you ever been prescribed psychiatric medications(s) in the past? **Yes No** (circle one)
If **yes**, please list medication(s) and dosage: _____

6. Are you currently taking any other substance(s) (i.e.: recreational drugs, non-prescribed psychiatric or general medication(s), illicit substances, etc.)? **Yes No** (circle one)
If **yes**, please list substance(s) and dosage: _____

And, approximately how many times per week are you are you consuming the abovementioned substance(s)? _____

Family Background

1. Please list current members of your family, including significant others if not married:

Name	Age or Date of Birth	Occupation/Year in School

2. Please list any information about your family relationships (i.e. divorce, extended family issues, past abuse experienced or witnessed as a child, etc.): _____

3. Have any of your family members ever been diagnosed with an emotional disorder, such as depression, anxiety, bi-polar disorder, etc.? **Yes No** (circle one)
If **yes**, please explain: _____

4. Have any of your family members ever been diagnosed with any learning issues or disabilities?
Yes No (circle one)
If **yes**, please explain: _____

Legal Concerns

1. Are you or any immediate family members currently involved in any court case? **Yes No** (circle one)
If **yes**, please describe: _____

2. Are you currently involved in divorce mediation or a custody case? **Yes No** (circle one)
If **yes**, please describe: _____

3. Is there currently a custody agreement in place? **Yes No** (circle one)
If **yes**, please describe agreement: _____

Please list anything else you would like your Studio For Change[®] therapist to know about you or your family before you initiate therapy:
