Adult Intake Questionnaire

Name: ______________________________ Age: __________ Date: ____________

Presenting problem and prior treatment

1. Who referred you or how did you learn about our services?

____

____

2. What is your major concern that led you to seek help?

____

____

____

3. What other concerns do you have?

____

____

____

4. Is there a particular reason you are seeking an appointment now?

____

____

Prior evaluations and treatment

5. Are you currently in counseling or therapy?

____

____

6. Have you ever had any evaluations for ADD/ADHD, learning problems or emotional/behavioral concerns?

____

____

7. How is your overall health Excellent _ Good Fair _ Poor __

8. Are you being treated for anything?

____

____

9. Have you ever taken medication for attention, behavior or mood problems? Yes No

If yes, **carefully** enter the following information for each medication in the table below.

Medication			
Dose			
Reason prescribed			
Age(s) when taken			
Length of time taken			
Prescribing Physician			
Benefits			
Problems			
If discontinued, why?			

List any medications you are currently taking for other health problems in the columns below.

Medication			
Dose			
Purpose			
Date Started			
Physician			
Side Effects			

10. Have you ever had any: Age(s) Details

Migraines ________ ____

Chronic pain ________ ____

Allergies or food sensitivities ________ ____

Frequent ear infections or colds ________ ____

Serious illnesses ________ ____

Major surgeries ________ ____

Vision difficulties (not glasses) ________ ____

Tinnitus (ringing in ears) ________ ____

Speech or hearing disorders ________ ____

Serious accidents/Injuries ________ ____

Head injuries ________ ____

Seizures ________ ____

Very sensitive to feel of labels, seams, textures in clothes ________ ____

Very sensitive to noises ________ ____

Very picky eater ________ ____

Developmental and Social History

11. Born where? ____________________ Raised where? ______________________________

    Were you adopted? Yes _ No _ If yes, at what age? ________

12. Any delays in learning to crawl, walk or talk? Yes _ No _ Unsure

13. Were you noticeably "hyperactive" as a preschooler? Yes No Unsure

14. Were you very anxious, fearful or shy as a preschooler? Yes No Unsure

Adverse Childhood Events

15. As a child or teenager, did you experience any of the following:

Did a parent or other adult in the household…

Often or very often swear at, insult, or put you down?	Yes _	No __
Often or very often act in a way that made you afraid that you would be physically hurt?	Yes	No
Often or very often push, grab, shove or slap you?	Yes _	No
Often or very often hit you so hard that you had marks or were injured?	Yes	No _
Did an adult or person at least 5 years older ever…		
Touch or fondle you in a sexual way?	Yes	No
Have you touch their body in a sexual way?	Yes _	No _
Attempt any type of sexual intercourse with you?	Yes	No
Actually have any type of sexual intercourse with you?	Yes	No _
Did you ever live with anyone who was a problem drinker or alcoholic?	Yes	No
Did you ever live with anyone who used street drugs?	Yes _	No _
Was a household member depressed or mentally ill?	Yes _	No
Did a household member attempt suicide?	Yes	No _
Was your mother (or stepmother)…		
Sometimes, often, or very often pushed grabbed, slapped, or had something thrown at her?	Yes _	No _
Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?	Yes _	No _
Ever repeatedly hit over at least a few minutes?	Yes _	No _
Ever threatened with, or hurt by, a knife or gun?	Yes _	No _
Did a household member go to prison?	Yes _	No _

Social relations and support

16. If married or in a committed relationship, how would you evaluate your relationship? ____________________

How are the presenting concerns affecting your relationship? ____

____

17. What are your sources of support such as family, friends, faith or spirituality?

____

____

18. What do you consider your greatest personal strengths?

____

____

Current Stresses

			How long has this been a problem?	How stressful? (1= Mild, 10= Very)
19. Are any of the following **current** source of stress?				
Concerns about a family member	Yes	No	________	____________
Marital/relationship concerns	Yes	No _	_______	____________
Adjusting to separation/divorce	Yes	No	_______	____________
Loss of friends/social isolation	Yes _	No _	_______	____________
School	Yes _	No __	_______	____________
Work	Yes _	No __	_______	____________
Health problems	Yes _	No __	_______	____________
Finances	Yes _	No __	_______	____________
Deaths or other losses	Yes	No	_______	____________
Other: ____			_______	____________

Details:____

____

Work History

20. What do you do for a living? ____

How is that affected by the presenting concern? ____

____

21. Consider problems you have had in the past with work including either performance issues or work satisfaction. How much do you feel those problems were related to the current presenting concern?:

____

____

22. How good are you at getting things done? Do you work well independently? Do you use lists to organize and keep track of what needs doing?

____

____

School History

23. What is the furthest grade reached or highest degree attained in school? _____________________

What was the Grade Point Average in your last schooling? ______________

24. As a youngster did you ever have

An Individualized Education Plan (IEP)? Yes For: ________________ Grades (s) __________

A 504 Plan of Accommodation? Yes For: ________________ Grades (s) __________

Special Ed or Resource Room class? Yes _ For: ________________ Grades(s) __________

 Please turn to next page

25. Please mark with a **+** any areas where you did especially well. Put a **-** where you have had problems. Put a **o** where you did about average.

	Elementary School	Middle School	High School	College
Reading	________	________	________	________
Math	________	________	________	________
Writing	________	________	________	________
Grades	________	________	________	________
Homework	________	________	________	________
Behavior at school	________	________	________	________
Peer relations	________	________	________	________
Attitude about school	________	________	________	________

26. If school was a problem, were any of the following tried in a consistent way?

			What grade(s)?	Helpful?
Systematic Rewards	Yes _	No _	____________	____________
Tutoring	Yes _	No _	____________	____________
Home schooling	Yes _	No _	____________	____________
Medications	Yes _	No _	____________	____________
Therapy	Yes	No _	____________	____________
Vision, speech or occupational therapy	Yes _	No _	____________	____________
Repeating a grade or subject	Yes __	No	____________	____________

27. Please circle any of the following that are current problems:

Difficulty reading

Reading hurts eyes or is tiring

Difficulty remembering what was read

Makes lots of careless mistakes in math

Difficulty remembering how to work math problems

Difficulty understanding math concepts

Difficulty at written composition

Difficulty spelling

Poor handwriting (even if writing slowly)

Difficulty drawing or copying figures

Difficulty keeping track of assignments

Difficulty organizing study time

Test Anxiety

Anxiety speaking in class

Attention problems

28. What problems do you have with daydreaming, staying on-task or being disorganized?

____

____

At what age was this first noticed at home? _______ Did teachers ever report this as something they noticed too?

____

29. What problems do you have with hyperactivity, stimulus seeking or feeling restless?

____

____

30. At what age was this first noticed at home? _______ Did teachers ever report this as something they noticed too?

____

31. What problems do you have with impulsivity, impatience or acting without thinking of consequences?

____

____

At what age was this first noticed at home? _________ Did this ever lead to your being hurt or in danger?

____

Oppositionality, anger and conduct problems

32. What problems do you have with being asked to do small tasks or requests? How much do you feel that any problems in this area come from not liking to be told to do things versus being distractible or disorganized?

____

____

33. What problems do you have with irritability and anger? When angry, are you more likely to let the anger go quickly or hold onto resentment?

____

____

34. When angry, does your temper frighten others? Do you ever become aggressive, violent or destructive?

____

____

35. Have you ever had problems with the law? If so, have those problems continued into the present? Do you feel there is any connection between your presenting concern and problems with the law?

____

____

Depression

36. What problems do you have with your feelings being too easily hurt or low self-esteem?

____

____

37. What problems, if any, do you have with depression?

____

____

38. If you are depressed, how much do you feel it may be directly a result of the major concern listed in question #2?

____

____

39. Are you now thinking of hurting yourself?

____

____

Anxiety

40. What problems do you have with anxiety?

____

____

41. Are there situations or activities you avoid because of anxiety or fear of not doing well?

____

____

42. In what ways do stress or anxiety cause you physical symptoms such as back or neck aches, headaches, intestinal problems or dizziness? How has that changed over time?

____

____

43. Have you ever suffered a trauma such that you continue to show fear or avoidance when reminded of any of these events or being in similar situations?

____

____

44. Do you have obsessive worries or compulsive behaviors?

____

____

45. What problems do you have with tics? These are repetitive movements or noises such as eye blinking, facial twitching, or noises such as grunting, snorting, squeaking, or humming.

____

____

Alcohol and drug use

46. Do you smoke cigarettes? Yes __ No _ If so, how much __________?
47. How much coffee or other caffeinated beverages do you drink? What effect does caffeine have?

____

____

48. Has anyone, including yourself, expressed concern about your alcohol use or have you ever sought help to control or stop drinking? Was this ever a problem when you were younger?

____

____

49. If you use drugs, has anyone expressed concern about your use or have you ever sought help to control or stop using? Was this ever a problem when you were younger?

____

____

Other Problems

50. Do you have problems with social awareness such as not being aware of how another person might be feeling, recognizing unstated rules of what is appropriate" or understanding body language or tone of expression?

____

____

51. Do you have problems with the rules of conversation? Do you have problems knowing when the listener has lost interest?

____

____

52. Do you often become so fascinated by one particular topic or interest such that it becomes all-consuming?

____

____

53. Do you become upset by changes in routine or have problems shifting from one activity to another?

____

____

54. Do you have problems with being either under or overly sensitive to the feel of clothing or to being touched or are you both over and under sensitive to pain?

____

55. Do you have problems with being overly sensitive to sounds or noise?

____

56. Do you have problems with being overly sensitive to smells or tastes? Are you a very picky eater?

____

57. Do you have problems with being especially sensitive to light or glare? Do you complain of room lights being too bright? ____

Other health related behaviors

58. Is there anything unusual about your diet or eating:____

____

59. How much activity or physical exercise do you get? :____

____

60. Please circle any of the following sleep problems you experience:

Difficulty falling asleep because mind too active	Restless sleep	Sleep walking
Delays going to bed	Sleeps unusual hours	Teeth grinding
Difficulty waking	Nightmares or vivid dreams	Snoring
Frequent waking	Sleeping too much	Bedwetting
	Fearful to sleep alone	Sleep Apnea

Family History

61. Put the letter symbol in the appropriate spaces.

Parents (M=Mother, F=Father) (History unknown __________)

ADD (distractible) Suspected _______ Treated for ______

ADHD (hyper/impulsive) Suspected _______ Treated for ______

Anxiety Suspected _______ Treated for ______

Depression Suspected _______ Treated for ______

Alcohol problems Suspected ______ Treated for _______

Drug problems Suspected ______ Treated for _______

Siblings (B=Brothers, S=Sisters) (Number of siblings)

ADD (distractible) Suspected _______ Treated for ______

ADHD (hyper/impulsive) Suspected _______ Treated for ______

Anxiety Suspected _______ Treated for ______

Depression Suspected _______ Treated for ______

Alcohol problems Suspected ______ Treated for _______

Drug problems Suspected ______ Treated for _______

Grandparents (M = Mother's parents, F = Father's parents) (History unknown __________)

ADD (distractible) Suspected _______ Treated for ______

ADHD (hyper/impulsive) Suspected _______ Treated for ______

Anxiety Suspected _______ Treated for ______

Depression Suspected _______ Treated for ______

Alcohol problems Suspected ______ Treated for _______

Drug problems Suspected ______ Treated for _______