Aspen Valley Wellness 801-224-1103

Adult Intake Questionnaire

Name: _____ Age: _____Date: _____

PRESENTING PROBLEM

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

_____
_____
_____
_____
_____

CURRENT MENTAL STATUS

					How long has this been a problem?	How stressful (1- Mild, 10- Very)
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:*_____

_____

Are any of the following current problems (Circle all that are applicable)?

Difficulty reading

Difficulty spelling

Reading hurts eyes or is tiring

Poor handwriting (even if writing slowly)

Difficulty remembering what was read

Difficulty drawing or copying figures

Makes lots of careless mistakes in math

Difficulty keeping track of assignments

Difficulty remembering how to do math problems

Difficulty organizing study time

Difficulty understanding math concepts

Test anxiety

Difficulty at written composition

Anxiety speaking in class

BACKGROUND INFORMATION

Prior evaluations and treatment

Are you currently in counseling or therapy? ___Yes ___No

Who do you see?_____

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

Health and Medical History

How is your overall health (circle one)? Excellent Good Fair Poor

Are you being treated for any medical conditions? ___Yes ___No

If yes, what? _____

_____

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			

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	_____	_____

Developmental and Social History

Born where? _____ Raised where? _____

Were you adopted? ___Yes ___No

If yes, what age? _____

Any delays in learning to crawl, walk or talk? ___Yes ___No ___Unsure

Were you noticeably "hyperactive" as a preschooler? ___Yes ___No ___Unsure

Were you very anxious, fearful or shy as a preschooler? ___Yes ___No ___Unsure

Adverse Childhood Events

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

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

_____

How are the presenting concerns affecting your relationship?

_____

_____

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

_____

_____

What do you consider your greatest personal strengths?

_____

_____

Depression

Are your feelings easily hurt or do you have low self-esteem? ___Yes ___No

Do you have problems with depression? ___Yes ___No.

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

_____

_____

Do you have thoughts of hurting yourself? ___Yes ___No

Anxiety

Do you have problems with anxiety? __Yes __No

Are there situations or activities you avoid because of anxiety or fear of not doing well?___Yes ___No
Do stress or anxiety cause you physical symptoms such as back or neck aches, headaches, intestinal problems or dizziness? ___Yes ___No

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? ___Yes ___No

Do you have obsessive worries or compulsive behaviors? ___Yes ___No

Do you have any tics? These are repetitive movements or noises such as eye blinking, facial twitching, or noises such as grunting, snorting, squeaking, or humming. ___Yes ___No

Oppositionality, anger and conduct problems

Is it hard being asked to do small tasks or requests? ___Yes ___No

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?

_____
_____
_____

Do you have and problems with irritability and anger? ___Yes ___No

When angry, are you more likely to let the anger go quickly or hold onto resentment?

_____
_____

When angry, does your temper frighten others? ___Yes ___No

Do you ever become aggressive, violent or destructive? ___Yes ___No

Have you ever had problems with the law? ___Yes ___No

If yes, have those problems continued into the present? ___Yes ___No

Do you feel there is any connection between your presenting concern and problems with the law?

_____
_____

Attention Problems

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? _____
_____

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

_____
_____
_____

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

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?_____
_____

Alcohol and drug use

Do you smoke cigarettes? ____Yes ___No

If so, how much? _____

How much coffee or other caffeinated beverages do you drink? What effect does caffeine have?_____
_____

Has anyone, including yourself, expressed concern about your alcohol use or have you ever sought help to control or stop drinking? ___Yes ___No

Was this ever a problem when you were younger? ___Yes ___No

If you use drugs, has anyone expressed concern about your use or have you ever sought help to control or stop using? ___Yes ___No

Was this ever a problem when you were younger? ___Yes ___No

Work History

What do you do for a living?_____
How is that affected by the presenting concern? _____
_____

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?

_____
_____

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

What is the furthest grade reached or highest degree attained in school? _____

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

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 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	_____	_____	_____	_____

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	☐	_____	_____

OTHER QUESTIONS

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? ___Yes ___No

Do you have problems with the rules of conversation? ___Yes ___No

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

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

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? ___Yes ___No

Do you have problems with being overly sensitive to sounds or noise? ___Yes ___No

Do you have problems with being overly sensitive to smells or tastes? ___Yes ___No

Are you a very picky eater? ___Yes ___No

Do you have problems with being especially sensitive to light or glare? Do you complain of room lights being too bright? ___Yes ___No

Other health related behaviors

Is there anything unusual about your diet or eating:_____

_____

How much activity or physical exercise do you get? :_____

_____

Please circle any of the following sleep problems you experience:

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