



ADULT INTAKE QUESTIONNAIRE

Name:		DOB:		Age:	
Gender:		Race/ethnicity/ancestry:			
Marital status:		Occupation:			
Reason for seeking services (motivation, need, problem, symptoms, issues, concerns):					
How long have you had these needs, symptoms, or issues?					
Have you had treatment for these issues in the past?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you received inpatient mental health treatment?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Briefly describe mental health treatment history (dates and name of facility/therapist):					
Have you had treatment for substance use?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Briefly describe substance use treatment history (dates, name of facility/therapist, substance concern):					
Do you have a family history of mental health concerns or substance use? If so, please describe:					
Describe the impact of the current emotional or behavioral struggles on family, employment, and social life:					



Describe your strengths and unique qualities:	

Are you currently under the care of a physician or psychiatrist? If yes, please provide the following:	
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Doctor's name:	
Address:	
Phone:	
Treatment for:	
Medications:	

Have you ever experienced an upsetting event or situation? (abuse, neglect, abandonment, bullying, loss of a loved one or pet, moving, surgery, pain) If you feel comfortable, please briefly describe below:	
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Have you ever witnessed an upsetting event or situation? If you feel comfortable, please briefly describe below:	
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Symptom Checklist					
Symptom	Current	Past	Symptom	Current	Past
Crying, sadness, depression	<input type="checkbox"/>	<input type="checkbox"/>	Temper outbursts, aggression	<input type="checkbox"/>	<input type="checkbox"/>
Loss of enjoyment in usual activities	<input type="checkbox"/>	<input type="checkbox"/>	Irritability, anger	<input type="checkbox"/>	<input type="checkbox"/>
Desire to die	<input type="checkbox"/>	<input type="checkbox"/>	Argues frequently	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted	<input type="checkbox"/>	<input type="checkbox"/>	Disobedience	<input type="checkbox"/>	<input type="checkbox"/>
Made suicidal gestures/attempts	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
Worries more than others	<input type="checkbox"/>	<input type="checkbox"/>	Unusual fears or phobias	<input type="checkbox"/>	<input type="checkbox"/>
Panics	<input type="checkbox"/>	<input type="checkbox"/>	Anxious, nervous	<input type="checkbox"/>	<input type="checkbox"/>
Repeats unnecessary acts	<input type="checkbox"/>	<input type="checkbox"/>	Is overly concerned	<input type="checkbox"/>	<input type="checkbox"/>
Exhibits rituals, habits, superstitions	<input type="checkbox"/>	<input type="checkbox"/>	Twitches, unusual movements	<input type="checkbox"/>	<input type="checkbox"/>
Eats very little/fasts to lose weight	<input type="checkbox"/>	<input type="checkbox"/>	Gorges or binge eats	<input type="checkbox"/>	<input type="checkbox"/>
Sleep walking	<input type="checkbox"/>	<input type="checkbox"/>	Blames others for own mistakes	<input type="checkbox"/>	<input type="checkbox"/>
Withdrawn	<input type="checkbox"/>	<input type="checkbox"/>	Easily annoyed by others	<input type="checkbox"/>	<input type="checkbox"/>
Nightmares, night terrors	<input type="checkbox"/>	<input type="checkbox"/>	Low motivation	<input type="checkbox"/>	<input type="checkbox"/>
Low self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	Disorientation	<input type="checkbox"/>	<input type="checkbox"/>
Wakes up very early	<input type="checkbox"/>	<input type="checkbox"/>	Vomits intentionally	<input type="checkbox"/>	<input type="checkbox"/>
Tiredness, fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Injures self intentionally	<input type="checkbox"/>	<input type="checkbox"/>
Restless sleep, wakes frequently	<input type="checkbox"/>	<input type="checkbox"/>	Struggles with friendships	<input type="checkbox"/>	<input type="checkbox"/>
Trouble falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	Feels shy around others	<input type="checkbox"/>	<input type="checkbox"/>
Excessive sleep	<input type="checkbox"/>	<input type="checkbox"/>	Grief or loss	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	Feelings of worthlessness	<input type="checkbox"/>	<input type="checkbox"/>
Under or over weight	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	Drug use	<input type="checkbox"/>	<input type="checkbox"/>
Frequently acts without thinking	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol use	<input type="checkbox"/>	<input type="checkbox"/>
Does not complete tasks	<input type="checkbox"/>	<input type="checkbox"/>	Cigarette use	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted	<input type="checkbox"/>	<input type="checkbox"/>	Mood swings	<input type="checkbox"/>	<input type="checkbox"/>
Academic struggles	<input type="checkbox"/>	<input type="checkbox"/>	Ideas of harming others	<input type="checkbox"/>	<input type="checkbox"/>
Worries about money	<input type="checkbox"/>	<input type="checkbox"/>	Disorganized thoughts	<input type="checkbox"/>	<input type="checkbox"/>
Concerned about family members	<input type="checkbox"/>	<input type="checkbox"/>	Problems at work	<input type="checkbox"/>	<input type="checkbox"/>
Relationship problems	<input type="checkbox"/>	<input type="checkbox"/>	Feelings of hopelessness	<input type="checkbox"/>	<input type="checkbox"/>
Daydreams, fantasizes	<input type="checkbox"/>	<input type="checkbox"/>	Problems with the law	<input type="checkbox"/>	<input type="checkbox"/>
Additional symptoms not listed above:					
Family Stressors					
Stressor	Current	Past	Stressor	Current	Past
Marital struggles	<input type="checkbox"/>	<input type="checkbox"/>	Housing problems	<input type="checkbox"/>	<input type="checkbox"/>
Marital separation	<input type="checkbox"/>	<input type="checkbox"/>	Legal issues	<input type="checkbox"/>	<input type="checkbox"/>
Divorce	<input type="checkbox"/>	<input type="checkbox"/>	Death of a friend	<input type="checkbox"/>	<input type="checkbox"/>
Custody disputes	<input type="checkbox"/>	<input type="checkbox"/>	Death of a relative	<input type="checkbox"/>	<input type="checkbox"/>
Financial problems	<input type="checkbox"/>	<input type="checkbox"/>	Death of a pet	<input type="checkbox"/>	<input type="checkbox"/>
Job loss	<input type="checkbox"/>	<input type="checkbox"/>	Family illness	<input type="checkbox"/>	<input type="checkbox"/>
Partner using alcohol/drugs	<input type="checkbox"/>	<input type="checkbox"/>	Intimate partner violence	<input type="checkbox"/>	<input type="checkbox"/>
Additional stressors not listed above:					



Medical History				
Condition	Yes	No	Age	Details
Serious infection	<input type="checkbox"/>	<input type="checkbox"/>		
Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>		
Head injury	<input type="checkbox"/>	<input type="checkbox"/>		
Other injuries	<input type="checkbox"/>	<input type="checkbox"/>		
Medical hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>		
Surgeries	<input type="checkbox"/>	<input type="checkbox"/>		
Poisoning	<input type="checkbox"/>	<input type="checkbox"/>		
Allergies	<input type="checkbox"/>	<input type="checkbox"/>		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		
Complications from alcoholism	<input type="checkbox"/>	<input type="checkbox"/>		
Complications from drug use	<input type="checkbox"/>	<input type="checkbox"/>		
Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>		
Other:				
Other:				
Other:				
Family Information				
List all of the people who currently live with you				
Name	Age	Relationship	Occupation/grade in school	
Who are your supports? (friends, faith, clubs, etc.)				
What are your goals for treatment?				

 Client (print) Signature Date

 Provider (print) Signature Date