

## Adult Intake Questionnaire

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

### Presenting problem and prior treatment

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

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

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3. What other concerns do you have?

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

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### Prior evaluations and treatment

5. Are you currently in counseling or therapy?

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

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**Health and Medical History**

7. How is your overall health    Excellent            Good                      Fair            Poor        

8. Are you being treated for anything?

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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?

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18. What do you consider your greatest personal strengths?

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**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) \_\_\_\_\_



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?

	Yes	No	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                               | 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 work math problems | Difficulty organizing study time          |
| Difficulty understanding math concepts           | Test Anxiety                              |
| Difficulty at written composition                | Anxiety speaking in class                 |



**Attention problems**

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

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

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

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

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

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

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**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?

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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?

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

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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?

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**Depression**

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

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

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

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39. Are you now thinking of hurting yourself?

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**Anxiety**

40. What problems do you have with anxiety?

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

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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?

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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?

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44. Do you have obsessive worries or compulsive behaviors?

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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.

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**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?

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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?

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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?

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**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?

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

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

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

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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?

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

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

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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<br>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 \_\_\_\_\_)

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|------------------------|-----------------|-------------------|
| 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)

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|------------------------|-----------------|-------------------|
| 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 \_\_\_\_\_)

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|------------------------|-----------------|-------------------|
| 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 _____ |

