Adult Intake Questionnaire

Anna Orcutt, MEd, LPC, NCC

Client Name: _____ **DOB:** _____ **Date:** _____

Please read the following questions and answer to the best of your ability by placing a checkmark or fill in the blank as directed. Your cooperation is appreciated.

Referred by: _____

Please state in your own words why you have sought counseling today:

_____

_____

_____

_____

_____

_____

_____

Please check ALL of the following symptoms or thoughts that apply to you **AT THIS TIME or during the past six months:**

____ Depressed mood
____ Diminished interests or pleasure
____ Sleep disturbance
____ Fatigue
____ Change in appetite
____ Hopelessness
____ Pleasure in few activities
____ Weight change
____ Agitation
____ Excessive worry
____ I feel like I am losing control
____ Irritability
____ Poor Concentration
____ Tension
____ Feelings of panic
____ Socially withdrawn
____ Use of alcohol
____ Use of other drugs
____ Use of tobacco
____ Anxiety in social settings
____ Makes careless mistakes
____ Does not complete tasks
____ Difficulty organizing
____ Forgetful
____ Confusion
____ Disorientation
____ Compulsive checking / counting
____ Indecisiveness
____ People talk about me
____ Some people want to hurt me
____ I feel emotionally distant from others
____ I hear voices or sounds others do not
____ I see things others do not
____ I smell things others do not
____ Racing thoughts
____ I do risky or dangerous things
____ Little interest in sexual activity
____ Sexual problems
____ Gender concerns
____ I do not like my body
____ Binge eating
____ Self-induced vomiting
____ Laxative abuse
____ Excessive fasting
____ Intense fear of weight gain
____ Impulsive
____ I think about hurting myself
____ I have tried to hurt myself
____ Sometimes I wish I were dead
____ I think about hurting someone else
____ Exposed to a significant traumatic event
____ Recurrent distressing dreams

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Psychiatric History:

I have received treatment for:
____ Substance abuse ____ Mental health issues ____ Both

The treatment occurred at:
____ Other private psychiatrist ____ Mental Health Center ____ Hospital
____ Other counseling service ____ Other facility _____

Are you presently being treated? ____ Yes ____ No
If yes, by whom?

_____

_____

Medical History:

Current weight _____ Height _____

Name of your primary care doctor _____

Phone _____ Date last seen _____

Do you have a history of any medical problem? ____ Yes ____ No
If so, what?

_____

_____

Are you presently being treated for any medical problem? ____ Yes ____ No
If so, what?

_____

_____

Past surgeries:

_____

_____

_____

_____

_____

Date of last Menses: _____

What form of birth control do you use? _____

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Have you ever been treated for a nutritional problem? ____ Yes ____ No
Do you make yourself sick because you feel uncomfortably full? ____ Yes ____ No
Do you worry you have lost control over how much you eat? ____ Yes ____ No
Have you recently lost more than 14 pounds in a 3 month period? ____ Yes ____ No
Do you believe yourself to be fat when others say you are too thin? ____ Yes ____ No
Would you say that food dominates your life? ____ Yes ____ No

Are you experiencing any physical pain? ____ Yes ____ No
If so, where?

_____

Have you ever received treatment for any of the following medical conditions?

____ Neurological impairment
____ Asthma
____ Seizure disorder
____ Emphysema
____ Visual loss / impairment
____ Chronic bronchitis
____ Hearing loss / impairment
____ Tuberculosis / +PPD
____ Dementia
____ Cancer
____ GI disorder
____ Thyroid disease
____ Obesity
____ Diabetes
____ Significantly underweight
____ Pregnancy
____ Cirrhosis
____ Irregular menstrual periods
____ Hepatitis
____ Musculoskeletal condition
____ Heart condition
____ HIV / AIDS / Related condition
____ Hypertension
____ Other _____

Please list any medications you are presently prescribed (name, dosage, frequency, doctor).

_____
_____
_____
_____
_____

Thank you for your cooperation and patience. Your therapist will see you shortly and discuss these and other issues in greater detail and help you develop an effective treatment plan.