FAMILY RESOURCES ASSOCIATES, INC.

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INTAKE QUESTIONNAIRE – ADULT

Your responses to the following items/questions will help your therapist better understand you and your situation in order to provide the best possible service. Please fill out as completely as you can and bring with you to your first therapy appointment. The information you provide is confidential and protected by law. Date:_____

IDENTIFYING INFORMATION (for individual receiving services)

Client:_____DOB:_____Name of Spouse/Partner:_____

Address:_____City, Zip_____Referred by:_____

Home Phone:_____Cell Phone:_____Social Security Number:_____

1. Sex: _ Male _ Female

2. Age: ___ Years

3. Partner/Marital Status:
__ Never Married
__ Living together
__ Married
__ Separated
__ Divorced
__ Widowed

4. Current Employment
__ Full-time
__ Part-time
__ Homemaker
__ Unemployed
__ Laid off
__ Student
__ Disabled
__ Retired

5. Education
__ Grade 8 or less
__ Some high school
__ High school graduate
__ Some college
__ College graduate
__ College beyond BS/BA

6. Children in the Family __ None

Name & Relationship (i.e. step)	Sex (circle)	DOB & Age (list)	Primarily living in your home?
_____	Male Female	_____	Yes No
_____	Male Female	_____	Yes No
_____	Male Female	_____	Yes No
_____	Male Female	_____	Yes No
_____	Male Female	_____	Yes No
_____	Male Female	_____	Yes No

Others living in household (please list names, relationships & ages):_____
_____

7. Primary Physician:_____City:_____Phone:_____

List any current medications & dosage (including psych meds):_____
_____
_____

Past Psychiatric meds:_____

8. Please check the appropriate box if you have experienced any of these problems:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Sinus/Allergy Problems
- ☐ Head injury
- ☐ Convulsions or seizures
- ☐ Memory problems
- ☐ Extreme tiredness or weakness
- ☐ Cancer
- ☐ Stomach or Bowel problems
- ☐ Asthma or Breathing problems
- ☐ Loss of consciousness
- ☐ Frequent or severe headaches
- ☐ Sleep disturbances
- ☐ Neck stiffness, pain, swelling
- ☐ Thyroid disease or goiter
- ☐ Skin problems
- ☐ Heart disease
- ☐ Marked weight changes
- ☐ Circulatory problems
- ☐ Other_____

9. Have you received prior counseling or related services? ☐ Yes ☐ No
If yes, please provide the name of the therapist seen, clinic name, date range of services, reason for seeking counseling at that time and a rating of how helpful the services were to you:_____

_____

_____

_____

10. If you feel that the therapist should be aware of any special treatment considerations due to gender, age, sexual orientation or cultural, religious, national, racial or ethnic identity, please explain below:_____

_____

_____

11. Please describe any involvement you have had with the legal system (arrests, convictions, probation, parole):

_____

_____

12. Military service: ☐ Yes ☐ No

13. Occupation: _____

14. Current employer: _____Phone:_____

15. Occupational History:_____

_____

16. Financial Status:__No problems __Some difficulty __Great difficulty __Bankruptcy Date of Bankruptcy:____

17. Relationship History:_____

_____

18. Please check any of the reasons listed below which led you to seek treatment, circling up to the 3 **most important**:

__ Communication problems
__ Sexual orientation
__ Social isolation or other social challenges
__ Trouble controlling impulses
__ Depression
__ Anxiety/Worry
__ Alcohol/Drug use
__ Abuse or trauma
__ Mood changes
__ ADHD symptoms
__ Parenting issues
__ Eating concerns
__ Thoughts of harming self or others
__ Learning/memory problems
__ Grief/Difficulty with loss or death
__ Anger/Conduct issues
__ Court-ordered services
__ Divorce counseling
__ Family counseling
__ Marriage/Couples counseling
__ Employment issues/Work-related problems
__ Partner/family member wanted me to come
__ Other: _____

19. In your own words, regarding the **most important** reason(s) that led you to seek treatment, please explain the history of this issue/these issues including frequency of symptoms, length of current episode, any previous episodes and how this issue/these issues affect your daily functioning:_____

_____

_____

_____

20. What questions do you hope will be answered? _____

_____

_____

21. Is there any additional information you'd like the therapist to know before your first appointment?

_____

_____

Client Name:_____ **DOB:**_____

FAMILY HISTORY

1. Were drugs or alcohol a problem in your family when you were growing up? ☐ Yes ☐ No
   If yes, please explain:_____

2. Do you or another immediate/extended family member have a history of alcohol or drug problem?
   ☐ Yes ☐ No If yes, please explain:_____

3. Please describe your current alcohol consumption:_____

5. Please describe your current drug use (if applicable):_____

6. Was there any type of abuse (physical, sexual, domestic or emotional) in your family or home?
   ☐ Yes ☐ No If yes, please describe the circumstances:_____

GOALS

1. What are your strengths? _____

2. What are your weaknesses? _____

3. What goals would you like to see reached as a result of your involvement in treatment?_____

4. How will you know when these goals have been reached?

Client Signature:_____ **Date:**_____

THERAPIST REVIEW

Signature: _____ Date: _____