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Center for Psychological and Educational Assessment

Adult Intake Questionnaire

Name: _____Today's Date: _____

Age: _____ Date of Birth_____

Address:_____
_

Home phone:_____ Ok to leave message? Yes No

Work phone:_____ Ok to leave message? Yes No

Cell phone: _____ Ok to leave message? Yes No

Email:_____

Referred by:_____

May we acknowledge the referral?_____

Reason you are seeking services:

_____

_____

_____

_____

_____

Present psychological difficulties – please check any that apply to you at this time.

_____ Generalized Anxiety (across many situations)
_____ Specific fears/phobias (list):_____
_____ Panic attacks
_____ Social Anxiety
_____ Obsessive thinking or compulsive behaviors
_____ Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)
_____ Sadness or Depression
_____ Emotionally overwhelmed
_____ Frequent crying
_____ Loss of energy
_____ Loss of pleasure in life
_____ Self-injurious / Self-harm behavior
_____ Thoughts of suicide
_____ Problems with eating
_____ Problems falling asleep
_____ Problems sleeping through the night (middle of the night waking or early morning waking)
_____ Trouble waking up
_____ Fatigue/tiredness during the day
_____ Nightmares
_____ Problems with attention or concentration
_____ Racing thoughts
_____ Problems making or keeping friends
_____ Problems controlling temper
_____ Relationship/Marriage problems
_____ Problems with intimacy
_____ Problems with job
_____ History of abuse (emotional, physical, sexual)
_____ Alcohol/drug use/abuse
_____ Financial problems
_____ Legal situation

Other:_____

_____

Describe any previous mental health services you have received (evaluations and therapy). Include the provider, any diagnoses, and length of treatment.

_____

_____

_____

_____

_____

What do you wish to accomplish (what are your goals) in seeking services at this time?

_____

_____

_____

GENERAL HEALTH:

Your current health: _____ excellent _____ good _____ fair _____ poor

Primary physician's name: _____

When was your last physical exam? _____Any relevant findings? _____

Are there any other physicians you see on a regular basis? _____

Describe any medical conditions that you have been diagnosed as having and any significant medical procedures you have had (surgeries, etc.).

_____

_____

_____

List any medications you take regularly. Include your prescriptions, over the counter medicines, vitamins, and supplements.

_____

_____

Any problems with sleep? Describe. _____

Any problems with eating? Describe. _____

Please rate the overall level of stress in your life:

_____Very Low
_____Low
_____Average
_____High
_____Very High

What do you consider to be the greatest source of stress at this time?

_____

_____

Rate your overall level of happiness on a scale of 1-5 (1 = UNHAPPY, 5 = HAPPY). _____

Are you a past or present smoker?_____
Length of time, number of cigarettes and frequency: _____

Do you use alcohol?_____ Number of drinks and frequency?_____

Do you drink caffeinated beverages?_____

FAMILY INFORMATION:

Marital Status (circle one):

Single Living with partner Married Separated Divorced Widowed

Rate quality of present relationship/marriage (if applicable):

_____ very good _____ good _____ fair _____ poor _____ very poor

Your occupation: _____

Occupation of spouse/partner: _____

If divorced, what are the custody arrangements? _____

Who currently resides in your home?

_____

_____

Has anyone in the birth family had any of the following psychological disorders? Check all that apply and list who (self, mother, father, sibling, child):

Yes	Condition	Family Member
_____	Mental Retardation	_____
_____	Speech or Communication Disorder	_____
_____	Attention-Deficit / Hyperactivity / Impulsivity	_____
_____	Learning Problems / Disabilities	_____
_____	Autism Spectrum / Asperger's Disorder	_____
_____	Sleep disorders	_____
_____	Generalized Anxiety (across many situations)	_____
_____	Social Anxiety	_____
_____	Obsessive-Compulsive Disorder	_____
_____	Phobias	_____
_____	Depression	_____
_____	Manic-Depression / Bipolar Disorder	_____
_____	Suicide attempts / Suicide	_____
_____	Schizophrenia or other psychosis	_____
_____	Alcohol / Substance Abuse	_____
_____	Seizures or other neurological disorder	_____
_____	Genetic Disorder (e.g., Down Syndrome, Fragile X)	_____

Other:_____

_____

DEVELOPMENTAL HISTORY

Place of birth: _____ Weight at birth:_____

Birth complications (check if applicable):

_____ Low birth weight _____Premature

_____ Oxygen Deprivation _____ Deformity (Specify: _____)

_____Jaundice _____ Illness (Specify: _____)

Mother's condition during pregnancy (as far as you know): _____

_____

Developmental Milestones (approximate age in months):

_____ Turned from back to stomach _____ Talked

_____ Sat alone without support _____ Walked

_____ Stood alone _____ Potty trained

EDUCATIONAL HISTORY (Complete those that apply):

	Average Grades	Dates Attended	Graduated
Elementary			
High School			
College/Post Graduate/Tech/Vocational			

Special education or tutoring (nature of help and grades):

_____

_____

_____

Did you ever participate in speech/language therapy, occupational therapy, or other therapies? Type of therapy and approximate ages: _____

_____

_____

_____

If you quit school prior to graduating high school, what were the reasons:

_____

If college,

Major:_____ School: _____

Degree(s): _____ Graduated:_____

Parents' education and occupations:

_____

Any other issues/concerns that you feel are relevant:

_____