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Adult Intake Questionnaire

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Name: _____
(First) (Last) (Middle Initial)

Preferred Name (if different):_____

Birth Date:_____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Never Married ☐ Domestic Partnership ☐Married ☐ Separated
☐ Divorced ☐Widowed ☐ Common-law married

If in a relationship currently, how long? _____

Please list any children you have:

Name	Age	Gender	Relation (Biological/Step/Other)

(If you need more space, please write on back of form)

Demographic Information:

Address:_____

City:_____ State: _____ Zipcode:_____

Home Phone: _____ May we leave a message? ☐Yes ☐No

Cell/Other Phone: _____ May we leave a message? ☐Yes ☐No

E-mail: _____ May we email you? ☐Yes ☐No

If needed, may we text you regarding non-confidential information such as appointment reminders or changes?

☐ Yes ☐ No

Emergency Contact (used only in situations of medical emergency) Name: _____

Phone Number: _____

Referred to Amy Urbanek, LPC, NCC, PLLC by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No

☐ Yes, Previous therapist/mental health practitioner: _____

How long ago were you seen? _____

How long did you see them? _____

What did you see them for and what was helpful or not helpful?

_____

_____

If you've seen multiple providers for mental health please continue to list them here:

_____

_____

_____

_____

You may continue to list them on the back of this sheet if necessary.

Have you ever been prescribed psychiatric medication?

☐ Yes

☐ No

If yes, please list what medications, who prescribed them and if you are currently taking them:

_____

_____

_____

Are you currently taking any other prescription medication?

☐ Yes

☐ No

If yes please list the medications and conditions it is treating:

_____

_____

_____

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

   Poor Unsatisfactory Satisfactory Good Very good

2. Please list any specific health problems you are currently experiencing:

   _____

   _____

3. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

4. Please list any specific sleep problems you are currently experiencing:

_____

_____

5. Do you engage in exercise on a regular basis? ☐ Yes ☐ No

If yes, how often do you exercise on a weekly basis?

_____

What types of exercise to you participate in:

_____

_____

6. Please list any difficulties you experience with your appetite or eating patterns.

_____

_____

7. Are you currently experiencing any chronic pain? ☐ Yes ☐ No

If yes, please describe? _____

8. Do you drink alcohol more than once a week? ☐ Yes ☐ No

If yes, how often do you drink alcohol each week? _____

9. Do you currently use or have you in the past engaged in recreational drug use? ☐ Yes ☐ No

If yes, What substances do you use or have you used in the past?

_____

When was the last time you used recreational drugs?

_____

Personal History

1. Where were you born and where were you raised?

_____

_____

2. Who were your primary caregivers growing up? (both biological parents, adopted, mother and stepfather, single mother, etc.)

_____

_____

3. Were you an only child or did you have siblings? Please describe:

_____

_____

4. What is the highest level of education you completed? _____

5. Are you currently employed? ☐ Yes ☐ No
   If yes, what is your current occupation? _____

6. Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No

7. Describe your relationship history including history of divorce, long-term relationships, death or loss, how many times you've been married, how long you were together, and any abuse issues that may have occurred.

_____
_____
_____
_____

Family History

1. Is there any family history of mental illness that you are aware of? ☐ Yes ☐ No
   If yes, please describe the family member's relationship to you and their mental health issues:

_____
_____
_____

Current Information about Your Life

What symptoms are you currently experiencing or struggling to cope with? (anxiety, depression, etc)

_____
_____
_____

What significant life changes or stressful events have you experienced recently:

_____
_____
_____

What would you like to accomplish out of your time in therapy?

_____
_____
_____