ADULT CLIENT INTAKE QUESTIONNAIRE

Thomas Joseph Doherty, Psy.D., Licensed Psychologist

Name: _____ Today's Date: _____
First Middle Last

Gender: M __ F __ Age: ___ Ethnicity: _____ Birth Date: _____ SSN: _____

Address: _____ City, State, Zip: _____

Telephone(s): _____ _____ _____ _____
(home) (cell) (work) partner (work)

E-mail 1: _____ e-mail 2: _____

May we leave messages for you? □ on home phone □ on work phone □ on email □ other _____ □ No

□ I live alone □ Others living in the home □ Significant others outside the home

Name: Age: Relationship:	Name: Age: Relationship:	Name: Age: Relationship:	Name: Age: Relationship:

Emergency contact: _____Phone: _____Relationship: _____

Referred by: _____

	Education	Occupation	Employer
Self			
Partner			

STRENGTHS & ISSUES

Describe the issues or problem(s) that brought you here today:

When did these problems begin?

STRENGTHS & ISSUES CONTINUED

What is going well in your life?

Hobbies & Interests?

How are your family relationships (current family and family of origin)?

Do you have any health issues or injuries?

What are your goals for this visit?

Is there any other information that may be helpful (for example, issues of diversity, spirituality or significant recent events)?

Check any of the symptoms that you are having:			
Depression		Feeling hopeless	
Extreme sadness		Feeling tearful	
Trouble concentrating		Change in sleeping habits	
Memory problems		Lack of energy	
Change in eating habits		Weight changes	
Feeling of extreme happiness		Change in sexual interest or function	
Trouble performing your job		Problems getting along with friends or family	
Lack of enjoyment of usual activities		Feeling stressed	
Self-esteem problems		Easily irritated	
Perfectionism		Feeling guilty	

Obsessions or compulsions		Feeling nervous	
Feeling fearful		Sudden feelings of panic	
Physical complaints of pain		Muscle tension	
Problems with anger		Acting violently	
Thoughts of hurting yourself or others		Thoughts of killing yourself or others	

HAVE YOU EVER BEEN IN COUNSELING BEFORE? Yes [ ] No [ ]

If you have been in counseling before, please describe it below. Start with the most recent time first.

A Date(s):	
Provider Name:	
Explain what happened:	

B. Date(s):	
Provider Name:	
Explain what happened:	

C. Date(s):	
Provider Name:	
Explain what happened:	

MEDICAL INFORMATION

Have you seen a doctor within the last year?	Yes [ ] No [ ]
Why have you seen a doctor?	
Who is your doctor? : Location:	Phone:
Are you taking any medications, prescription or over-the-counter? Please describe:	Yes [ ] No [ ]

Medications	Dosages
1.	
2.	
3.	
4.	

SUBSTANCE USE HISTORY

Do you use/ have you used tobacco (any form)?	Current [ ]	Past [ ]	No [ ]
Do you use/ have you used alcohol?	Current [ ]	Past [ ]	No [ ]
Do you use/ have you used caffeine (any form, including cola drinks)?	Current [ ]	Past [ ]	No [ ]
Do you use/ have you used other mind-altering substances (drugs)? If yes, please describe:	Current [ ]	Past [ ]	No [ ]
1.	Current [ ]	Past [ ]	
2.	Current [ ]	Past [ ]	
3.	Current [ ]	Past [ ]	
4.	Current [ ]	Past [ ]	

IF THERE IS OTHER INFORMATION THAT YOU THINK IS IMPORTANT,
PLEASE ATTACH ADDITIONAL SHEETS