



INTAKE QUESTIONNAIRE – ADULT

Your response to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.

Name of person completing form: _____ Date: _____

IDENTIFYING INFORMATION (for individual receiving services)

Name: _____ Date of Birth: _____

Address: _____ Sex: _____

_____ Marital Status: _____

Home Phone: () _____ Work Phone: () _____

Social Security Number: _____ Household Income: \$ _____

Who referred you to CSSW? _____

Race:

- | | |
|--|---|
| <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> Asian |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Black/African American |
| <input type="checkbox"/> Native Hawaiian or Pacific Islander | <input type="checkbox"/> Two or more races |
| <input type="checkbox"/> Unknown | |

Ethnicity:

- Hispanic or Latino
 Non-Hispanic or Non-Latino

Language of Choice:

- | | |
|----------------------------------|---------------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Hmong | <input type="checkbox"/> German |
| <input type="checkbox"/> Russian | <input type="checkbox"/> French |
| <input type="checkbox"/> Laotian | <input type="checkbox"/> Other: _____ |

Religious Affiliation:

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Catholic | <input type="checkbox"/> Protestant (including Lutheran, Methodist, etc.) |
| <input type="checkbox"/> Muslim | <input type="checkbox"/> Non-Denominational |
| <input type="checkbox"/> Jewish | <input type="checkbox"/> No Affiliation |
| <input type="checkbox"/> Amish | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Mennonite | |

Disability:

Do you have a disability? Yes No If yes, please specify: _____

If you have a disability, does the office accommodate your needs? Yes No

If no, please explain: _____

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:

PRESENTING PROBLEM (current situation and history)

1. What is the primary problem for which you are seeking help? (please circle)

- | | | |
|-----------------------------|---------------------------|-----------------------|
| a. Marriage or relationship | g. Problems with children | m. Grieving |
| b. Family problems | h. Peer problems | n. Abuse or trauma |
| c. Depression | i. Eating disorder | o. Sexual functioning |
| d. Mood swings | j. Alcohol/drug use | p. Anger |
| e. Behavior | k. Physical problems | q. Anxiety or worry |
| f. Self-confidence | l. Work related | r. Other (explain): |

2. How long have you had this/these problem(s)? _____

3. Have you received treatment for this problem or any other problem in the past? Yes No

If yes when, where and with whom? _____

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 family member have a history of alcohol or drug problem? Yes No

If yes, please explain: _____

3. Please describe your current alcohol consumption: _____

4. Was there any type of abuse (physical, sexual, domestic or emotional) in your family or home?

Yes No If yes, please describe the circumstances: _____

5. Have you or any other family member experienced any type of abuse? Yes No

If yes, please explain: _____

LEGAL HISTORY

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

CURRENT FAMILY INFORMATION

1. Please provide the following information:

Name (First and Last)	Date of Birth	Lives with You?	
Spouse/Significant Other:		Yes	No
Children: _____		Yes	No
_____		Yes	No
_____		Yes	No
_____		Yes	No
Others Living in Household:			

2. Highest educational level achieved: _____

3. Military service: Yes No

4. Occupation: _____

5. Current employer: _____

MEDICAL HISTORY

1. Primary Care physician/pediatrician: _____

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

- | | |
|--|--|
| <input type="checkbox"/> Eye disease, injury, poor vision | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Ear disease, injury, poor hearing | <input type="checkbox"/> Bowel problems |
| <input type="checkbox"/> Nose, sinus, mouth, throat problems | <input type="checkbox"/> Hemorrhoids, rectal bleeding |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Convulsions or seizures | <input type="checkbox"/> Frequent or severe headaches |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Sleep disturbances |
| <input type="checkbox"/> Extreme tiredness or weakness | <input type="checkbox"/> Neck stiffness, pain, swelling |
| <input type="checkbox"/> Thyroid disease or goiter | <input type="checkbox"/> Marked weight changes |
| <input type="checkbox"/> Skin disease | <input type="checkbox"/> Circulatory problems |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Allergies or asthma |
| <input type="checkbox"/> Back, arm, leg or joint problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Encephalitis |
| <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Premenstrual Syndrome (PMS) | <input type="checkbox"/> Pregnancy not carried to term/stillbirths |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Liver, gallbladder disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chest pain or angina pectoris | |

Please explain anything checked above: _____

3. Please provide information about medication(s), prescription or over-the-counter, which you take regularly:

Medication	Dosage/Frequency	Prescribing Physician	For what condition?

4. Please list significant hospitalizations, operations, injuries (including broken bones): _____

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 with CSSW?

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

THERAPIST REVIEW

Signature: _____

Date: _____