Client Intake Questionnaire - Adult

General Information

Name: _____ _____

Last First

Today's Date: _____

If student, school attending:

_____

Highest education completed: _____

Satisfaction with school (1-10, 1 = lowest) _____

Occupation: _____

Satisfaction with job (1-10, 1 = lowest) _____

Place of employment: _____

Length of employment: _____

Presenting Concern

Reason for seeking services:

Did a specific event lead to this search for service? If yes, please describe the incident:

Other relevant history of the problem(s):

Please describe what you hope to accomplish in this therapy or what you hope will be different in your life when this therapy is helpful to you.

Client Initials:_____

One Love Counseling
10 Glenlake Parkway #130
Atlanta, GA 30328
www.OneLoveCounseling.com

Mental Health History

Other therapy or counseling treatment you've received in the past or are receiving now (Please indicate when and for how long):

Have you ever been hospitalized for psychological problems? If yes, when and where?

Have you ever attempted suicide? If yes, when?

Current medications & dosage (if applicable): Please describe any family history of mental illness or substance abuse:

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Substance Use

Please indicate which best describes your use of the following substances. If daily, please indicate amount:

	DAILY/AMOUNT	WEEKLY	OCCASIONALLY	IN THE PAST, BUT NOT NOW	NOT AT ALL
CAFFEINE / ENERGY DRINKS					
TOBACCO					
ALCOHOL					
PRESCRIPTION NARCOTICS					
INHALANTS					
COCAINE / METH / AMPHETAMINE					
OPIATES / SEDATIVE - HYPNOTICS					
HALLUCINOGENS					
CANNABIS					
OTHER:					

Have you or anyone else ever been concerned about your use of any of the above substances? If yes, describe:

Have you ever had treatment for any type of substance use? If yes, when? And please describe:

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Legal History

Please note any legal difficulties, including pending charges, arrests, convictions, probation, nature of charges, etc.:

Medical History

Please list any significant health problems, past or present, including surgeries, illness, head traumas, and/or important accidents or injuries with the corresponding dates:

Family Information & Significant Relationships

Please provide names of any significant relationships you'd like to mention.

FIRST NAME	Age	RELEVANT INFORMATION (e.g., Date of Death, City/State, Occupation(s), Religion)
Grandparents:	**Age:**	**Relevant Information (Optional)**
Aunts & Uncles (Paternal)	**Age:**	**Relevant Information (Optional)**
Aunts & Uncles (Maternal)	**Age:**	**Relevant Information (Optional)**
Parents & Step-parents	**Age:**	**Relevant Information (Optional)**

Brothers & Sisters	**Age:**	**Relevant Information (Optional)**
Children (if applicable)	**Age:**	**Relevant Information (Optional)**

Other Significant Relationships: (e.g., Partner, Partner's Family Members, Important Friendships, Roommates, etc.)
Quality of interpersonal relationships and social interactions:

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Check any of these that apply:

- Depressed, sad or crying
- Grieving
- Guilty feelings
- Suicidal thoughts, plans or attempts
- Self-harm (e.g. cutting)
- Thoughts of harming others
- Difficulty falling or staying asleep
- Fatigue, always feeling tired
- Nightmares
- Increase or decrease in weight or eating habits
- Lack of interest in recreation/pleasurable activities
- Problems managing daily self-care tasks
- Apathy
- Inability to focus
- Lack of direction
- Lack of meaning in life
- Anxious, nervous or panicky feelings
- Panic attacks / anxiety attacks
- Fears/phobias
- Avoiding places or situations
- Insecurity or inferiority
- Repetitive thoughts or behaviors
- Anger or temper problems
- Headaches or body aches
- Upset stomach
- Memory problems
- Confused or disorganized thoughts
- Seeing/hearing things that aren't there
- Paranoia
- Loneliness
- Being picked-on or taken advantage of

- Relationship dissatisfaction/problems
- Conflicts with others
- Problems making or keeping friendships
- Social alienation / Not fitting in
- Not wanting to be around other people
- Substance abuse or dependence
- Sexual abuse
- Physical abuse
- Emotional abuse
- Fighting
- Hyperactivity
- Staying up all the time, but never feeling tired
- Financial problems
- Impulsive spending
- Illegal activities
- Sexual worries or problems
- Sexual orientation or identity concerns
- Learning disability
- Religious/spiritual concerns
- Problems at work and/or school
- Other: _____

Please list anything else important to understand you/help you (Please consider including hobbies, interests, social life, volunteer work, etc. As well as any ethnic, religious, political or other communities with which you identify, etc.):