

**Couple & Family Institute of Tri-Cities
8121 W. Quinault Ave. Suite F202
Kennewick, WA 99336
509-579-0200 Office ~ 509-232-0216 Fax**

ADULT INTAKE QUESTIONNAIRE

In order for us to be able to fully evaluate you, please fill out the following questionnaire to the best of your ability. We realize there may be information that you do not remember or have access to. Please just do the best you can. Thank you!

PATIENT IDENTIFICATION:

Name: _____ 1st Appt Date: _____
Birth Date: _____ Age: _____ Sex: _____
Religion: _____ Marital Status: _____
Race: _____ Children: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work: _____ Cell: _____
Email address: _____

REFERRAL SOURCE:

Who referred you to our office? _____
Address: _____ Phone: _____
Do we have your permission to release information to the referring professional when it is appropriate? _____ Yes _____ No

PURPOSE OF THE CONSULTATION:

(Please give a brief summary of the main problems)

WHY DID YOU SEEK THE EVALUATION AT THIS TIME?

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PRIOR ATTEMPTS TO CORRECT PROBLEMS

PRIOR PSYCHIATRIC HISTORY

(Please include contact with other professionals, medications, types of treatment, etc.)

What do you want this clinic to do for you?

MEDICAL HISTORY:

Are you currently suicidal? Have you attempted suicide in the past? _____

Current medical problems/medications: _____

Past Medical Problems/medications: _____

Other doctors/clinics seen regularly: _____

Any history of head trauma: (describe): _____

Ever any seizure like activity? _____

Any periods of "spaciness" of confusion? _____

Prior hospitalizations (place, cause, date, outcome): _____

Allergies/drug intolerances (describe): _____

Present Height: _____ Weight: _____

CURRENT LIFE STRESSES (Include anything that is currently stressful for you: examples include relationships, job, school, finances, children): _____

FAMILY HISTORY:

Family structure (who do you currently live with, add other information as necessary):

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Significant Developmental Events (include marriages, separation, divorces, deaths, traumatic events, losses, abused, etc): _____

Current Marital or Relational Situation/Satisfaction: _____

History of Past Marriages: _____

Natural Mother History: age: _____ outside work: _____

School: Highest grade completed: _____

Learning Problems (Specify): _____

Behavioral Problems (Specify): _____

Marriages: _____

Medical Problems: _____

Childhood atmosphere: (family position, abuse, illnesses, etc) _____

Has mother ever sought psychiatric treatment? Yes _____ No _____

If yes, for what purpose? _____

Mother's alcohol/drug use history: _____

Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify) _____

Natural Father's History: age: _____ outside work: _____

School: Highest grade completed: _____

Learning problems (specify): _____

Behavior problems (specify): _____

Marriages: _____

Medical problems: _____

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Childhood atmosphere (family position, abuse, illnesses, etc): _____

Has Father ever sought psychiatric treatment? Yes _____ No _____

If yes, for what purpose? _____

Father's alcohol/drug use history: _____

Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify) _____

Siblings (names, ages, problems, strengths, relationship to patient):

Children (names, ages, problems, strengths)

EDUCATIONAL HISTORY

Last grade completed: _____

Last School Attended: _____

Average grades received: _____

Any academic problems: _____

Learning strengths: _____

What would your teachers have said about you? _____

Employment History: (summarize jobs you've had, list most favorite and least favorite:

Any work-related problems? _____

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What would you employers or supervisors have said about you? _____

Military History: _____

Ever Any Legal Problems? _____

Alcohol and Drug History: (Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel: what benefit you got from them). These include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine, or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP.

Ever experience withdrawal symptom for alcohol or drugs? _____

Has anyone ever told you they thought you had a problem with drugs or alcohol? _____

Have you ever felt guilty about your drug or alcohol use? _____

Have you ever felt annoyed when someone talked to you about your drug or alcohol use?

Have you ever used drugs or alcohol first thing in the morning? _____

Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew)

Cultural/Ethnic Background: _____

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Describe your relationships with friends: _____

Describe yourself: _____

What are your goals in seeking this consultation? What do you hope to gain?
