SONOMA COUNTY COUNSELING

Adult Intake Questionnaire

Date: _____

General Info

Full Legal Name: _____

Preferred Name _____ Gender: _____

Date of Birth: _____ Social Security Number (optional): _____

Home Phone: _____ OK to leave messages at this phone number? ☐Yes ☐No

Cell Phone: _____ OK to leave messages at this phone number? ☐Yes ☐No

Work Phone: _____ OK to leave messages at this phone number? ☐Yes ☐No

Preferred number for contact: _____

Email: _____ OK to send emails to this email address? ☐Yes ☐No

Address: _____

City: _____ State: _____ ZIP: _____

OK to send mail to this address? ☐Yes ☐No

Who lives in the household (names, ages, relation): _____

_____

_____

Relationship Status: ☐Single ☐Married/ Domestic Partnership ☐Partnered (not married)

☐Divorced ☐Widowed ☐Other: _____

Name of Spouse / Partner(s) / Significant Other(s): _____

_____

Emergency Contact: _____ Relationship: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone No. & Type: _____ Phone No. & Type: _____

Primary Physician: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

How do you intend to pay for treatment? (private pay, insurance, etc): _____

If utilizing insurance:

Name of Insurance Company: _____

Policy No.: _____ Group No.: _____

Plan Code: _____ Co-Payment: _____

Subscriber (Name of primary insured): _____

SSN: _____ Relation to client: _____

Member Services Phone: _____

Employment & Education

Are you currently employed: ☐ Yes ☐ No

Place of Employment: _____ Job Title: _____

Address: _____

City: _____ State: _____ ZIP: _____

How many hours do you work per week: _____

Did you graduate High School: ☐ Yes ☐ No ☐ GED ☐ Other _____

Highest level of education (include degree & area of study): _____

Currently enrolled in School or training program: ☐ Yes ☐ No

School Name & Location: _____

Area of study: _____

Date began: _____ Expected date of completion: _____

Areas of Concern

What issues/concerns cause you to seek treatment at this time?

_____

_____

_____

_____

_____

Do you have any specific goals/outcomes in mind with regard to your treatment?

_____

_____

_____

_____

_____

Do you have any particular concerns/fears with regard to treatment?

_____
_____
_____
_____

Psychiatric History

Have you ever been diagnosed with a mental health condition: ☐ Yes ☐ No

Please list diagnoses, date diagnosed, and who provided diagnoses:

_____
_____
_____
_____

Have you participated in outpatient mental health treatment before: ☐ Yes ☐ No

When and for how long? _____
_____
_____

What was the focus of treatment? _____
_____
_____
_____
_____

Do you believe treatment was beneficial? Please describe: _____
_____
_____
_____

Name of treating Therapist/ Physician, address, and phone number:

_____
_____
_____

Have you ever been hospitalized for psychiatric/ psychological issues: ☐ Yes ☐ No

When and for how long? _____
_____
_____

For what condition(s) were you hospitalized? _____
_____
_____
_____
_____

Are you currently taking any medications for psychiatric/ psychological issues: ☐ Yes ☐ No
Prescribing Physician: _____
List medications, dosages, and reason for taking them:
_____
_____
_____

Are you currently taking any other medications, prescribed and/or over the counter: ☐ Yes ☐ No
List medications and reason for taking them:
_____
_____
_____

Have you ever participated in a drug treatment or 12-Step program: ☐ Yes ☐ No
Please describe: _____
_____
_____
_____

Do you use tobacco products: ☐ Yes ☐ No What do you use? _____
How much? _____ For how long? _____

Do you drink alcohol: ☐ Yes ☐ No
On average, how much alcohol do you consume in a week? _____

Have you used any other substances in the last 12 months: ☐ Yes ☐ No
What have you used? _____
_____
_____
_____

Have you experienced any recent loss, major changes, or stressors in your life: ☐ Yes ☐ No
Please describe: _____
_____
_____
_____

Have you ever attempted suicide: ☐ Yes ☐ No When? _____
Describe the circumstances surrounding previous attempt(s): _____
_____
_____
_____

Are you currently having any suicidal thoughts: ☐ Yes ☐ No

Please describe: _____

_____

_____

_____

History of mental illness, substance abuse, or suicide in family: ☐ Yes ☐ No

Please describe: _____

_____

_____

_____

_____

Medical History

Please describe your overall health today: _____

_____

_____

Have you ever been diagnosed with a chronic or serious illness/ condition: ☐ Yes ☐ No

Please describe: _____

_____

_____

Do you have any medical conditions that may affect your mental health treatment: ☐ Yes ☐ No

Please describe: _____

_____

_____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition: ☐ Yes ☐ No

Please describe: _____

_____

_____

_____

Other information

Please describe your childhood: _____

_____

_____

_____

_____

Have you ever been subjected to verbal, physical, emotional, or sexual abuse: ☐ Yes ☐ No

Please describe: _____

_____

_____

_____

Do you currently feel safe at home: ☐ Yes ☐ No

If not, please describe: _____

_____

_____

_____

Have you ever been a victim of a violent crime: ☐ Yes ☐ No

Please describe: _____

_____

_____

_____

Have you ever been arrested: ☐ Yes ☐ No

Please describe: _____

_____

_____

_____

Are you now or have you ever been involved in a lawsuit: ☐ Yes ☐ No

Please describe: _____

_____

_____

Please describe your spiritual beliefs & practices:

_____

_____

_____

Please describe your interests & hobbies:

_____

_____

_____

Do you belong to any communities (church, support groups, interest clubs, athletic teams, etc):

_____

_____

_____

Please describe some of your personal strengths:

_____
_____
_____

Who do you identify as main support people in your life?

_____
_____
_____
_____

Is there anything else you'd like to share related to your history or mental health treatment?

_____
_____
_____
_____
_____