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## Adult Intake Background Data

This questionnaire is to gather important background information on you that will assist us in providing you high quality care. Please answer the following questions to the best of your ability.

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Gender Identity: Male \_\_\_\_\_ Female \_\_\_\_\_ Transgender (\_\_\_\_MTF)\_\_\_\_FTM)\_\_\_\_Gender Neutral  
\_\_\_\_Non-Binary \_\_\_\_Additional category (please specify): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Form Completed by: (if someone other than patient) Name and Relationship : \_\_\_\_\_  
\_\_\_\_\_

### Presenting Problem

1. Please tell us the purpose for which you are seeking outpatient mental health services: (please select all that apply)

\_\_\_ Anger Management

\_\_\_ Anxiety

\_\_\_ Depression

\_\_\_ Fear/Phobias

\_\_\_ Confusion

\_\_\_ Work Issues

\_\_\_ Sleep Problems

\_\_\_ Sexual Concerns

\_\_\_ Stress

\_\_\_ Family/Marital Problems

\_\_\_ Alcohol/Drugs

\_\_\_ Other Mental Health Concerns (specify): \_\_\_\_\_

### Mental Health / Drug and Alcohol Treatment History

Name of Agency/Therapist	Date/Year	Reason for Treatment

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Please Describe Your Experience With The Above Treatments If Applicable:

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Do You Currently Have A Psychiatrist?      Yes      No

If Yes, What Is His/her  
Name: \_\_\_\_\_

If Yes, Please complete the release of information form and include their name and address

**Substance Use History**

- |   |     |    |
|---|-----|----|
| 1. Do you currently drink alcohol?                        | Yes | No |
| 2. Have you consumed alcohol in the past?                 | Yes | No |
| 3. Are you or others concerned about your drinking        | Yes | No |
| 4. Do you currently use drugs?                            | Yes | No |
| 5. Have you used drugs in the past                        | Yes | No |
| 6. Are you or others concerned about your drug use?       | Yes | No |
| 7. Do you smoke cigarettes or use other forms of nicotine | Yes | No |
| 8. If yes, how much per day? _____                        |     |    |
| 9. Are you interested in quitting?                        | Yes | No |
| 10. Do you drink caffeine                                 | Yes | No |
| 11. If yes, how much per day? _____                       |     |    |

**Medical History**

- |   |     |    |
|---|-----|----|
| 1. Do you have a family or primary care physician | Yes | No |
| 2. May we contact him/her                         | Yes | No |

If yes: Please complete the release of information form and include their name and address

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Have you had any of the following:

1. Past or present medical illnesses? Yes No
  2. Hospitalization/Operations Yes No
- If Yes, list year and type:

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3. Head injuries or loss of consciousness Yes No
- If Yes, please describe:

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4. Are you currently taking any medications? (Including Psychiatric Yes No

Prescriptions, Supplements, Herbs or Over-The-Counter Medications) If Yes, please list:

Medication	Dosage/How Many Times Per Day

**Family Medical History**

1. Is there any history in your family of:  
Alcoholism/Alcohol Abuse Yes No If Yes, whom (please list) \_\_\_\_\_  
Drug Abuse or Dependence Yes No \_\_\_\_\_  
Heart Disease Yes No \_\_\_\_\_  
Diabetes Yes No \_\_\_\_\_  
High Blood Pressure Yes No \_\_\_\_\_  
Psychiatric Problems Yes No \_\_\_\_\_  
Suicide Attempts Yes No \_\_\_\_\_

**Family Background/Family of Origin**

1. How old is your father? \_\_\_\_\_ If deceased, at what age? \_\_\_\_\_
  2. Does/Did he have any health problems? Yes No
- If yes, describe:

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Quality of relationship with him:

---

3. How old is your mother? \_\_\_\_\_ If deceased, at what age? \_\_\_\_\_

Does/Did she have any health problems?

Yes No

If yes, describe:

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Quality of relationship with her:

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4. If any, how old is/are your brother (s) and/or sister(s)?

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If deceased, at what age? \_\_\_\_\_

Does/Did they have any health problems?

Yes No

If yes, describe:

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Quality of relationship with them:

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5. Are your parent's: Married Divorced Separated Never Married Remarried

6. What was it like for you growing up in your family?

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7. How was discipline handled in your family?

---

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**Current Family**

1. What is your current marital status:

Married Divorced Never Married Separated Widowed Living Together

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2. If applicable, how long have you been/were married?

\_\_\_\_\_

If applicable Name and age of  
spouse: \_\_\_\_\_

3. If applicable, how many times have you been married?

4. If not married, are you in a relationship?

Yes No

5. Do you have any children?

If yes, what are their ages? \_\_\_\_\_

Yes No

6. Have family problems ever resulted in referral to  
County Children and Youth Services?

Yes No

7. Who currently resides in your home?

8. If applicable, what is it like living in your current family or being in your current relationship?

### **Developmental History**

1. Were there any problems prior to or during your birth that may have influenced your  
development?

If yes, specify: \_\_\_\_\_

Yes No

2. Were there any problems during your infancy or childhood that may have influenced your  
development?

If yes, specify: \_\_\_\_\_

Yes No

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3. Have you ever had any history of physical, emotional or sexual abuse? Yes No  
If yes, specify: \_\_\_\_\_
4. Have you ever been witness to abuse Yes No  
5. Have you had/have a partner who humiliates you or calls you names? Yes No  
6. Have you had/have a partner that has been violent towards you? Yes No  
7. Age of first sexual experience: \_\_\_\_\_
8. Sexual Orientation (circle one): Heterosexual Homosexual Bisexual Asexual
9. Do you have concerns regarding sexuality? Yes No  
If yes, explain: \_\_\_\_\_

**Social History**

1. What are your current hobbies or interests?  
\_\_\_\_\_  
\_\_\_\_\_

2. Are there any past hobbies or interests that you no longer are active in? Yes No  
If yes, what are they  
\_\_\_\_\_  
\_\_\_\_\_

Check how you generally get along with other people: (check all that apply)

\_\_\_ Affectionate \_\_\_ Aggressive \_\_\_ Avoidant \_\_\_ Fight/Argue Often  
\_\_\_ Friendly \_\_\_ Leader \_\_\_ Outgoing \_\_\_ Shy/Withdrawn  
\_\_\_ Submissive \_\_\_ Other Specify: \_\_\_\_\_

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### Educational History

1. What is your highest degree completed?  
Grade \_\_\_\_\_ High School Diploma GED Some College College Grad Post Grad
2. How did you do in elementary school? A's B's C's D's F's
3. If applicable, how did you do in high school? A's B's C's D's F's
4. If applicable, how did you do in college? A's B's C's D's F's
5. How well did you get along with your teachers at school? Good Fair Poor
6. Were there problem teachers? Yes No  
If yes, describe:  
\_\_\_\_\_  
\_\_\_\_\_
7. How well did you get along with the other students in your class? Good Fair Poor  
  
Were there any problems with peers? Yes No  
Were you ever teased or bullied? Yes No  
If yes, describe  
\_\_\_\_\_  
\_\_\_\_\_
8. Do you have any learning problems? Yes No  
If yes, describe:  
\_\_\_\_\_  
\_\_\_\_\_
- If yes, have you received treatment for them? Yes No

### Employment History

1. What is your current employment status?  
Employed Unemployed Disabled Retired  
Other: \_\_\_\_\_  
If disabled, explain disability;  
\_\_\_\_\_  
\_\_\_\_\_

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2. If employed, where are you employed?

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3. What is your position?

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4. How long have you been employed in your current position?

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5. How many jobs have you had in the past?

---

6. What is the longest amount of time you have held a job?

---

7. If no employed, list your job skills:

---

**Military History (please skip if not applicable)**

1. What branch are/have you served?

---

2. Have you ever served in combat?

Yes No

3. What is your discharge status?

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**Legal History**

1. Are you currently involved in any legal proceedings?

Yes No

2. Have you ever been arrested/charged/or incarcerated?

Yes No

3. Are you currently on parole or probation?

Probation

Parole

Neither

If so, who is your contact person?

---

May we contact them?

Yes No

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If yes: complete the release of information form and include their name, address and phone number

4. Do you have any past legal involvement? Yes No

**Spiritual/Religious History**

1. How important to you are spiritual matters? Not \_\_\_\_ Little \_\_\_\_ Moderate \_\_\_\_ Much \_\_\_\_
2. Are you affiliated with a spiritual or religious group? Yes No
3. Were you raised within a spiritual or religious group? Yes No
4. Would you like your spiritual/religious beliefs incorporated into the counseling? Yes No

**Cultural History**

1. With what race/ethnicity do you identify?  
\_\_\_\_\_
2. Are there important aspects (beliefs/practices) of your culture that we need to be aware of that will affect how we provide treatment?  
Specify:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Treatment Goals**

The changes I want to make are:  
\_\_\_\_\_  
\_\_\_\_\_

The most important reason I want to make these changes are:  
\_\_\_\_\_  
\_\_\_\_\_



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Other people who could help me in changing are:

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Ways they can help are:

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The things that could stand in my way of making changes are:

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My readiness for changes is best described as: *(circle the number that best describes how ready you are)*

1      2      3      4      5      6      7      8      9      10

*Not Ready*

*Totally Ready*

My confidence that I can achieve my goals is:

*(Circle the percentage that best describes your confidence in achieving your goals)*

0%                  25%                  50%                  75%                  100%

Signature of Patient:

---

Date:

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**If Patient is unable to sign:**

Patient Representative (Print Name):

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Patient Representative Signature:

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Date:

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