

# Adult Questionnaire

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Please answer the following questions to the best of your ability; your answers will assist me in better understanding your particular case. Any questions left unanswered will remain as questions upon your intake interview; therefore, please do your best. If you feel that any question is too personal, then you may inform me more about it when you come in, or choose not to divulge the information at all. I can only help to the degree that I may understand your particular case. This questionnaire will be treated as personal, confidential, protected information.

Date \_\_\_\_\_ How did you find out about us \_\_\_\_\_

Client Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ How long living at this address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Social Security No. \_\_\_\_\_

Work Phone \_\_\_\_\_ Drivers License No. \_\_\_\_\_

Cell Phone \_\_\_\_\_ Level of Education \_\_\_\_\_

Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_

Employment Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Current marital status Never Married \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_

You have been in the current marital status for how many years now? \_\_\_\_\_

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Spouse's Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Social Security No. \_\_\_\_\_

Work Phone \_\_\_\_\_ Drivers License No. \_\_\_\_\_

Cell Phone \_\_\_\_\_ Level of Education \_\_\_\_\_

Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_

Employment Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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Please enter names and ages of your children below: Total number of Children \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
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Name of your Insurance Provider \_\_\_\_\_

Group # \_\_\_\_\_ Contract/Member ID# \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

Insured's Place of Employment \_\_\_\_\_ Insured S.S. # \_\_\_\_\_

Employment Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

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Nearest Relative not living with you:

Person's Name \_\_\_\_\_ Phone No. \_\_\_\_\_

In case of Emergency contact person:

Person's Name \_\_\_\_\_ Phone No. \_\_\_\_\_

Are you currently in the care of a Physician ? \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone No. \_\_\_\_\_

Current Medications and reasons for seeing Physician \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you ever seen a Counselor, Therapist, Psychologist or Psychiatrist before? \_\_\_\_\_

If so, please give names, reasons, explanation, approx. dates: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please explain your reasons for coming in for therapy today: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

All of the information that I have provided herein is accurate and to the best of my ability. I have already reviewed and understand your Declaration of Practice and consent to the policies outlined; and want to be accepted as a client for treatment herein, as signed below:

Client's Signature \_\_\_\_\_ Date \_\_\_\_\_