

# Living Well Counseling Services, LLC

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[www.lwcounseling.com](http://www.lwcounseling.com)

## **Adult Intake Questionnaire**

Today's date \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth \_\_\_\_\_

Address: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ email \_\_\_\_\_

Circle areas in which you've noted difficulties or changes: sleep, appetite, crying, concentration, weight, social interaction, sexual activity, physical pains or sickness, panic, unusual behavior, depressive thinking, frightening thoughts, suicidal thoughts.

(For office use only)  
Presenting problems:

Have you experienced any significant life changes in the past year?

Explain \_\_\_\_\_

Have you previously been in therapy?      Yes      No

Previous therapy was related to \_\_\_\_\_

\_\_\_\_\_

List previous counseling experience, including dates and your response to therapy \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you recently been on any medications?      Yes      No

Type and dosage \_\_\_\_\_

\_\_\_\_\_

Physician's name, address, phone \_\_\_\_\_

Health concerns:

Have you ever been hospitalized?      Yes      No

Dates and reason \_\_\_\_\_

\_\_\_\_\_

AODA History:

Do you use alcohol?      Yes      No

Type, Amount & Frequency \_\_\_\_\_

Do you use tranquilizers (valium, librium, xanax, etc.), narcotics, cocaine, marijuana, amphetamines, or other substances?

Yes      No

Describe \_\_\_\_\_

Where did you grow up? \_\_\_\_\_

(For office use only)  
Family history:

Father's name \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_

Health \_\_\_\_\_

Marital status \_\_\_\_\_

If deceased, age, year, cause of death \_\_\_\_\_

\_\_\_\_\_

Mother's name \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_

Health \_\_\_\_\_

Marital status \_\_\_\_\_

If deceased, age, year, cause of death \_\_\_\_\_

\_\_\_\_\_

Siblings (include age)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there any illness or disorder that tends to run in your family?

Yes No Please explain \_\_\_\_\_

\_\_\_\_\_

Have any of your family (grandparents, parents, aunts/uncles, your siblings or your children) had any problems with the following?

|                    | Relative | Treatment |
|--------------------|----------|-----------|
| Alcohol/drug abuse |          |           |

Depression

Bi-polar disorder

Suicide

Other emotional disorders

Your present living situation: (circle one)

single, married, partner, divorced, separated, widowed

Present Family Info:

Length of marriage/relationship \_\_\_\_\_

Spouse's/partner's name \_\_\_\_\_

Age \_\_\_\_\_ Education \_\_\_\_\_

Occupation \_\_\_\_\_

Previous marriages \_\_\_\_\_

List children and step-children:      Date of birth      Living arrangement

(Office use)

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

Any difficulties with children? \_\_\_\_\_

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

Have you previously been married?      Yes      No  
Date(s) of marriage: \_\_\_\_\_

Years of education completed    9   10   11   12   13   14   15   more

Education history:

Degree received \_\_\_\_\_

Other education/training \_\_\_\_\_

Present occupation \_\_\_\_\_

Employment history:

How long with this job? \_\_\_\_\_ Are you satisfied with this job? Y/N

Religious upbringing and current involvement \_\_\_\_\_

Religious History:

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

Please list hobbies \_\_\_\_\_

Social interaction/support:

How do you use free time? \_\_\_\_\_

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

Describe your current support network \_\_\_\_\_

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

Is there any other information about you or your family that would be  
pertinent to your treatment? \_\_\_\_\_

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

\_\_\_\_\_  
Client's signature

\_\_\_\_\_  
Clinician's signature