Karen Nam, LCSW (OR # L5719)

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Adult Intake Questionnaire

Date: _____

Name: _____ DOB/Age: _____

Address: _____

City: _____ Zip: _____

Home Phone: _____ Okay to leave message Yes or No

Cell Phone: _____ Okay to leave message Yes or No

Work Phone: _____ Okay to leave message Yes or No

Emergency Contact Information – Name: _____

Address: _____ Phone: _____

Marital Status: Single Married Divorced/Separated Partnered Widowed

Please include dates of any divorce(s), remarriage(s), or spouse's death

_____

Names/Ages of Children or Stepchildren: _____

_____

Please list who currently lives in your household: _____

_____

Occupation/Employer: _____

Highest Level of Education:_____

Have you ever seen a counselor/therapist or mental health professional in the past? Yes / No

If so, what was the reason for seeking services at that time?
Was it helpful? Why or why not?

_____

_____

Are you currently taking any **medications** or supplements? Yes / No

If yes, please list medications (type, dosages, and reason prescribed) Who prescribes your medication?

_____

_____

Do you have any **health problems**? If so, please describe:

_____

_____

Do you **drink alcohol**? Yes / No If so, how often & how much?
Have you ever tried to cut down or control your drinking/drug use? Yes / No
Are you struggling with a drug or alcohol problem? Yes / No DUI's Yes / No

Do you use **illegal drugs**? Yes / No Past drug use? Yes / No

Have you ever sought treatment for a **substance abuse problem**? Yes / No

If so, what **treatment program** (Rehab facility) did you attend?
Ever attend AA or NA ? Yes / No

_____

_____

Other **Addiction problems** (past or current): Circle any that apply to you.

Pill Addiction Food Addiction Sexual Addiction Sex/Love Addicts Gambling

Eating Disorder (Bulimia, Anorexia, or Binge-eating): Yes / No
Have you ever been **hospitalized for psychiatric reasons**? Yes / No

If yes, please state reason and date of hospitalization: _____

Have you ever thought about hurting yourself/suicidal ideation? Yes / No

Past history of **suicide attempt**(s)? Yes / No

If yes, method of attempt and date? _____

History of the following in childhood? Circle any that you have experienced.

Sexual Abuse Physical Abuse Emotional Abuse/Neglect Traumatic experience(s)

Traumatic Events/Losses:

_____

Physical Violence in an Adult Relationship: Yes / No
(**Domestic Violence or Emotional Abuse**)

Reason for seeking counseling at this time? _____

_____

_____

What are your goals for therapy? _____

_____

_____

_____ Date _____

Client Signature

_____ Date_____

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