

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? _____

Client Signature Date _____

Karen Nam, LCSW Date _____