Sonoma Counseling Services
8911 Lakewood Dr. Suite 24F
Windsor, CA 95492
707-836-6350

Adult Intake Questionnaire

Date:

Name (Last, Middle Initial, First):
____
Street Address: ____________________________
City: ______________________ State: ___________
Home phone: _____________________________
Alternate phone: ___________________________ E-mail: ____________________________
Alternate E-mail: ____________________________
Please indicate the means by which you prefer to be contacted. You may check more than one: Phone: _____ Text: ____ E-mail: _____ Regular Mail: ____. If you would prefer to be contacted at a phone number, e-mail, or address other than what is listed above, please provide that information here:
____
Date of Birth: ______________ Age: ____

Gender:
Woman: ___ Man: ___ Transgender: ___ Transman: ___ Transwoman: ___ Gender Nonconforming: ___ Other: ____________________________

Orientation:
Straight: ___ Gay: ___ Lesbian: ___ Bisexual: ___ Asexual: ___
Queer: ___ Questioning: ___ Other: ____________________________
Prefer not to answer: ___

What type of services are you currently seeking? Please mark an "X" by the type of services you are seeking.

Individual therapy
Marital/Couples therapy
Family therapy
Group Therapy
Other (describe) Unsure

Goals of Treatment:
What compelled you to seek therapy at this time?
____
____
____
Describe your current concerns, issues, or problems that you hope to resolve:
____
____
____
____

What do you hope to gain from therapy?
____
____
____
____

Relationship Status (Please check all that apply):

Are you presently married or involved in a relationship? Yes_____ No_______
If you answered yes, how would you describe your current level of satisfaction with the relationship?
____
Have you married previously? If yes, when? ____
Name of the individual whom you identify as your significant other:
____
If you are married, or in a relationship, rate your level of contentment/happiness/satisfaction in the relationship on a scale of 1 to 10 (Number 1 indicates a sense of being very or extremely happy and the number 10 indicates a sense of being extremely unhappy). Briefly explain the rating you give in the space provided:
____
____
____
____

On a scale of 1 to 10, describe your level of commitment to your relationship (Number 1 indicates a sense of being very committed and the number 10 indicates a sense of not feeling at all committed). Briefly explain the rating you give in the space provided:
____
____
____
____
____

Source of Income:
Employment: ______ Unemployment: ______ Spouse/Significant Other: ______ Social Security: ______ Short Term-Disability: ____________________________ Other: ____

Current Employment Status (Please check all that apply):
Working Full-Time: _____ Working Part-Time: _____ Retired: ____________
On medical leave: ______________Unemployed and looking for work: _____ Not employed due to other reasons ____Full-Time Student: ______________
Part-Time Student: ____

Education Information: (Please check the *highest* level of education/degree you have received):
Elementary, Grades 1-8: _____ Some High School (no diploma): _____
High School Diploma/GED: _____Some College (no degree): ______ Technical/Trade School Graduate: _____Associate's Degree: ______ Bachelor's Degree: ______ Master's Degree: _____ Professional Graduate Degree (i.e., MD, JD, etc.):______ Doctoral Degree (i.e., PhD, EdD, etc.):______

Military History:
Currently on active duty: ________ Served in Military (please circle length of time served) for: ______ number of weeks, months, or years. Never served in the military: ________________
If you have served in the military were you ever deployed, yes or no? Yes: _____ No: ____.
If yes, please describe your deployment experience and any incidence or issues that arose for you during or after your deployment:
____
____
____
____

Legal History:
Have you been ordered by the court to participate in this therapy, yes or no?
Yes: ____ No: ____If yes, you may be required to supply supporting documentation such as a copy of the court order.

Are you currently involved in any kind of litigation or legal dispute, yes or no?
Yes: _____ No: _____ If yes, please explain (i.e., custody dispute, dissolution proceedings, etc.):
____
____
____

Emergency Contact Information: (Who you prefer me to contact in case of an emergency)
Name: _________________________ Relationship: __________________________________
Phone number: __________________ Email: ____

Referral Information:
Were you referred? Yes: ______ No: _____ I f referred, by whom?
____

Payment Information:
Please indicate how you intend to pay for treatment:
Cash: ___ Check: ___ Credit Card: ____ Employee Assistance Program: ____Insurance: _____
Third-Party: _______. If a third-party will be paying for your treatment please provide the following information: Name of the person paying for your therapy: ___________________
Your Relationship to this person: ____
Contact Information for this person: ____

If you are planning to use health insurance, please provide the following information:
Name of Insurance Company: ____
Subscriber's Name: ____ Insured's ID number: __________________________ Group Policy Number: _______ Co-Payment Amount: ___________
Insurance Claim's Mailing Address: ____
Telephone number: ____

Previous Mental Health Treatment History:
Have you participated in therapy? Yes: _____ No: ____ If YES, please complete the information below:

Name: ________________________ Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):____
Phone Number: _________________________ Email: ________________________________
Street Address: _________________ City: ____________________________ State: ________
Dates of treatment: ____
Focus of treatment: ____

Name: _________________________Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):____
Phone Number: _________________________ Email: ________________________________
Street Address: ___________________City: ____________________________ State: _______
Dates of treatment: ____
Focus of treatment: ____

Name: ________________________ Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):____
Phone Number: _________________________ Email: ________________________________
Street Address: ___________________ City: ____________________________ State: _______
Dates of treatment: ____

Focus of treatment: ____

Have you ever been hospitalized because of a mental health disorder, yes or no?
Yes: _____ No: _____. If you indicated that you have been hospitalized for a mental health disorder, please complete the following information:
Reason for hospitalization:

____
Was hospitalization voluntary or involuntary? Please check:
Voluntary: ______ OR Involuntary: ______
How long was your hospitalization?

____
Where were you hospitalized?
____
____
Course of treatment during hospitalization:
____
____
____
Provide the name of the providers who treated you below. Please indicate the type of provider (i.e., Psychiatrist, Psychologist, MD, Licensed Therapist).

Name: _________________________ Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):____
Phone Number: _________________________ Email: ________________________________
Street Address: __________________ City: ____________________________ State: _______
Dates of treatment: ____

Name: _________________________ Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):____
Phone Number: __________________________ Email: ________________________________
Street Address: ___________________ City: ____________________________ State: _______
Dates of treatment: ____

Name: __________________________Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):____
Phone Number: ___________________________ Email: ________________________________
Street Address: ___________________ City: ____________________________ State: _______
Dates of treatment: ____

Current Mental Health Treatment:
Are you currently participating in therapy or counseling? Yes: ____ No: _____ If YES, please complete the following information: ____

Name of Current Provider: ____

Type of provider: ____
Phone Number: ____________________ Email: ____________________________________
Street Address: _____________ City: ____________________________ State: ___________
Dates of Treatment: ____
Focus of Treatment: ____
Name of Current Provider: ____
Type of Provider: ____
Phone Number: _________________________Email: _________________________________
Street Address: ________________ City: ____________________________ State: ________
Dates of Treatment: ____
Focus of Treatment: ____

If you are currently receiving therapeutic services from another psychotherapist, to avoid a duplication of services, it may be necessary for me to contact your current psychotherapist to coordinate care. You may be required to sign and *"Authorization for Release of Confidential Information"* form which will be provided to you and maintained as part of your clinical record long with a copy of this patient intake form.* Please Initial: _______

If you are currently under the care of a psychiatrist, are you taking any prescribed psychiatric medication(s), yes or no? Yes ______ No_____. If you indicated that you are currently taking psychiatric medication, please list the type of medication, the specific medication you have been prescribed, the dosage, and any side effects in the space below.

For example: *"Antidepressant (type), Zoloft (specific medication), 50mg once daily (dose), Insomnia (side effect)."*
____
____
____
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____

If you are currently under the care of a psychologist, have you participated in any psychological assessments or tests yes, or no? Yes ____ No _____. If you have participated in psychological testing, please list the type of test performed, the specific name of the test, and the date(s) the test(s) were administered.

For example: *"Personality Test (Type), Minnesota Multiphasic Personality Inventory "MMPI-2" (Specific name of test), February 01, 2017 (Date test was administered)."*
____
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***California Civil Code Section, 56.10 states that information may be disclosed to "providers of health care or other health care professionals or facilities for purposes of diagnosis or treatment of the patient" without the patient's consent. By initialing, you acknowledge and understand that I may contact either your current or former mental health care and/or medical providers only to discuss issues relevant to your diagnosis and treatment without your consent. Initial: _________**

Medical Treatment Information:
Are you currently seeking treatment for a serious or chronic non-psychiatric medical condition, yes or no? Yes: ______ No: _____. If you currently have a medical condition, please provide the following information:
Current medical condition: ____
How long have you had the condition? ____
Is it a medically treatable condition, yes or no? Yes: ______________ No: ___________________
If, it is not a medically treatable condition (i.e., palliative care), please describe:
____
____
____
____
If you are currently taking prescribed medications for the condition please describe the type of medication, indicate how long you have been taking the medication, and any side effects.

For example: *"High blood pressure medication (type of medication); 2 years (length of time on medication); Drowsiness (example of a side effect)*.
____
____
____
____
____

Trauma History (Optional):
Have you been – or are you currently being – emotionally, physically, or sexually abused?
Yes _____ No _____ Prefer not to answer _____. If you checked "Yes," you may use the space below to describe the underlying circumstances:
____
____
____
____

____

Family of Origin Information (Optional):
Were you adopted, yes or no? Yes: ______ No: _______. If you were adopted, at what age were you adopted? ______ .
If you were adopted, do you have a relationship with your birth mother and/or father, yes or no? Yes: _____ No: _____If yes, please describe the nature of the relationship. For example, explain how the relationship with your biological parent(s) was established, how old you were at the time the relationship began, the frequency of contact you had or currently have, and the nature of the relationship:

____
____
____
____
____
____

If you were adopted, what type of relationship do you/did you have with your adopted parents?

____
____
____
____
____

If you were *not* adopted, what type of relationship do you/did you have with your biological parents?

____
____
____
____
____

Please provide the following information about your parents either (biological/adopted) or stepparent:

Name of Mother: ___________________________
Name of Father: ____________________________
Mother's occupation: ________________________
Father's Occupation: _________________________
Name of Stepmother: ________________________
Name of Stepfather: _________________________
Stepmother's Occupation: ____________________
Stepfather's Occupation: _____________________

Are either of your parents (biological or adopted, and/or step parents) deceased? If your parents are deceased, please provided the following information:

• Mother/Stepmother has been deceased for _______ days/weeks/months/years. What was your age at the time of your mother's/stepmother's passing? ________
• Father/Stepfather has been deceased for ______ days/weeks/months/years years. What was your age at the time of your father's/stepfather's death? ________

Indicate the marital status of your parents (biological/adopted). Check all that may apply:

• Currently married to each other for _____ years
• Currently separated for _____ years
• Divorced for ______years
• Mother remarried _____ times
• Father remarried _____ times
• Mother currently single after being separated/divorced for _____ years
• Father currently single after being separated/divorced for _____ years
• Mother is currently involved with someone, yes or no? If yes, for how long? ____________
• Father is currently involved with someone, yes or no? If yes, for how long? _____________

Do you have any biological siblings, adopted siblings, step siblings, or half siblings, yes or no? Yes: ____ No: ____. If you have any siblings, how many? _______. In the space provided below, list the name and ages of each of your siblings and briefly describe the nature of your relationship as being "close," or "not close," or "estranged," or any other word that describes the nature and extent of your relationship with your siblings.

____
____
____
____
____
____
____
____

Which of the following statements most resonates with you:

• My parents were present during my *entire* childhood, yes or no? Yes: _____No: ______.

Explain:____
____
____
____

• My parents were present during a *part* of my childhood, yes or no? Yes: ____ No: _____.
Explain:____
____
____
____

• My parents were *not present* at all during my childhood, yes or no? Yes: ____ No: ____.
Explain:
____
____
____
____

Which of the following describes your childhood family experience:

• ______ It was an outstanding home environment
• ______ It was a normal home environment
• ______ It was a chaotic home environment
• ______ Prefer not to answer

If you indicated that your home environment was chaotic, please explain. For example, you may have witnessed physical/verbal/sexual abuse towards others, or you may have experienced physical/verbal/sexual abuse from others:
____
____
____
____
____
____

Mental Health/Risk Assessment:
Please identify if you have experienced any of the following and whether this is a past, current, or reoccurring issue:
• _______ Suicidal Thoughts.
○ Past:______ Present: ______ Reoccurring: _____
• _______Thoughts of wanting to intentionally harm myself. ○ Past:______ Present: ______ Reoccurring: _____
• _______ Thoughts of wanting to intentionally cause harm to someone else. ○ Past:______ Present: ______ Reoccurring: _____
• _______ Post-Traumatic Stress.

- Past:______ Present: ______ Reoccurring: _____

If you are currently experiencing any thoughts of either harming yourself or someone else please answer the following questions:

How long have you had these thoughts?
____

How frequently do you have these thoughts?
____
____
____

Do you have a plan and/or the means to carry out either the threat of harm to yourself or to someone else, yes or no? Yes: _____ No: _____If yes, please explain:
____
____
____

Have you ever tried to harm yourself or anyone else in the past, yes or no? Yes: ____ No: ____If yes, please explain:
____
____
____

Is there anything that would stop, or prevent, you from harming yourself or someone else, yes or no? Yes: ____ No: ____ If yes, please explain?
____
____
____

If you indicated that there is not anything that would prevent you from harming yourself or someone else, please identify how likely it is that you might actually harm yourself or someone else:

Imminently likely: ______ OR Not at all likely: ______

Alcohol/Substance Use History (Optional):
Family Alcohol Abuse History: To the best of your knowledge, please indicate which of the following family member(s) struggles or struggled with alcohol/substance abuse or addiction:

Father: ___ Mother: ____ Grandparent(s): ____ Sibling(s): _____ Stepparent(s): _____
Uncle(s)/Aunt(s):____ Spouse/Significant Other: _____ Children: ______

Please indicate your substance use status:

No history of use: _____ Actively using alcohol or drugs: ____ In early full remission: ____ In early partial remission: _____In sustained full remission: _____
In sustained partial remission: _____

If you indicated that you have an alcohol/substance abuse or addiction history, please identify the types of treatment you have participated in, or are currently participating in, and how long you have been participating in the particular treatment.

Outpatient treatment:
____
Inpatient treatment:
____
12-Step Program:
____
Stopped using on my own:
____
Other Method:
____
Was the above treatment method effective? Please explain:
____
____

Please identify the type(s) of substances you are using, how frequently you use the substance, and how long you have been using the substance, and your frequency of use (i.e., daily, as needed, no regulation of use, etc.)
Opioid(s): ____ Classification: ____ Length of use: _____ Frequency of use: _____________
Heroin: ____ Length of use: _______ Frequency of use: _____________________________
Cigarettes/Tobacco: ___ Length of use: _____ Frequency of use: ______________________
Alcohol: ____ Length of use: _________ Frequency of use: ____________________________
Amphetamines: ____ Length of use: _______Frequency of use: ________________________
Barbiturates: ____Length of use: _____ Frequency of use: ____________________________
Cocaine: ___ Length of use: _____ Frequency of use: __________________________________
Crack: _____ Length of use: ___ Frequency of use: ___________________________________
Hallucinogens: _____ Length of use: ____ Frequency of use: ____________________________
Inhalants: _____ Length of use: ____Frequency of use: ________________________________
Marijuana: _____ Length of use: ____ Frequency of use: ________________________________
Other: _________ Length of use: ____ Frequency of use: ________________________________

If you have indicated that you have used, or are currently using substances, please indicate what side effects and or consequences you experienced or are experiencing as a result of the use.

Overdose: _____ Suicidal Impulse: _______ Depression: _______ Anxiety: _______________
Blackouts: _______ Loss of control: _______ Medical conditions: ________Other: _________
Please use the space provided to describe any other effects or consequences you have experienced:

____
____
____

Spiritual/Cultural History (Optional):
Do you identify with a particular religion, culture, or spiritual practice? If so, please describe:

____
____
____

Do any of the above religious, cultural, or spiritual issues contribute to your current concerns, problems, or issues? If so, please describe:

____
____
____

Additional Information
Please let me know in the space provided, of anything that was not addressed in this intake, and anything that you would like me to know about you, your goals, your relationships, or any recent significant life events:

____
____
____
____

Patient Signature: ____ Date: __________