Counseling Specialists
OF CENTRAL FLORIDA

ADULT INTAKE QUESTIONNAIRE

GENERAL INFORMATION

Date: ________________

Last Name: ________________________________ First Name: ________________________________ Middle Initial: ____

Prefix: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Rev. Nickname: ________________________________ Suffix: ______

Sex: ☐ Male ☐ Female Age: ______________ Date of Birth: ______________ Race/Ethnicity: ____________________

EMPLOYMENT INFORMATION

Employer: ____ Years Employed: _______

Job Title: ________________________________ Stable: ☐ Yes ☐ No Problems: ____________________________

EDUCATION INFORMATION

What is the highest grade completed? Check box below:

Are you currently in school? ☐ Yes ☐ No

Elementary: ☐ K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 School: ________________________________

Middle School: ☐ 6 ☐ 7 ☐ 8 School: ________________________________

High School: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED School: ________________________________

College: ☐ Trade School ☐ Associates ☐ Bachelors ☐ Masters ☐ Doctorate

Were you ever held back a grade(s), skipped a grade(s) and/or homeschooled? ☐ Yes ☐ No

MILITARY/FIRST RESPONDER INFORMATION

Have you, or your partner, ever served in the military? You: ☐ Yes ☐ No Partner: ☐ Yes ☐ No

Current Status: ☐ Enlisted ☐ Reserves ☐ Retired ☐ Discharged: ____________________

Branch of Service: ☐ Army ☐ Navy ☐ Air Force ☐ Marines ☐ Coast Guard

First Responder: ☐ FBI/CIA ☐ LEO ☐ EMT/Fireman ☐ Dr/Nurse/ER ☐ 911 Operator

Years of Service: _______ Injuries Received: ____________________________ Ongoing Issues: ☐ Yes ☐ No

RELATIONAL INFORMATION

Current status: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Length of current relationship status: ______________ Are you content with your current status: ☐ Yes ☐ No

If no, why? ____

If previously married, how many total marriages have you and your spouse had? You: ____________ Your spouse: __________

With whom do you currently reside? Check all that apply:

☐ Alone ☐ Parent(s) ☐ Sibling(s) ☐ Spouse

☐ Child(ren) ☐ Fiancé ☐ Girlfriend ☐ Boyfriend

☐ Friend(s) ☐ Pet(s) ☐ Other(s): ________________________

SPOUSE/PARTNER INFORMATION

Name: ____ Nickname: ____________________________

How long have you known him/her? ____________________________ Age: ___________ Sex: ☐ Male ☐ Female

Occupation: ____ Race/Ethnicity: ____________________________

Employment status: ☐ Unemployed ☐ Part-Time ☐ Full-Time ☐ Student

Highest Education Level: ☐ High School ☐ Trade School ☐ Undergrad ☐ Masters ☐ Doctoral

How would you describe him/her?

____

Counseling Specialists
OF CENTRAL FLORIDA

PRESENTING ISSUES AND GOALS

Briefly describe why you are coming to counseling (e.g. what are your concerns, problems, symptoms, etc.)?

____

____

What do you hope to gain or change by coming to counseling?

____

____

Over the past six (6) months have your symptoms: ☐ Improved ☐ Worsened ☐ No change

Are your currently experiencing any problems in the following aspects of your life? If so, please explain:

- ☐ Marital/Family: ____
- ☐ Financial/Legal: ____
- ☐ Educational/Occupational: ______________________________________
- ☐ Social/Personal: ____

Is there anything you (or someone else) can do that helps reduce the problem(s) or symptom(s)? If so, please describe:

____

____

Is there anything that seems to make the symptom(s) or problem(s) worse? If so, please describe:

____

____

Have others commented about changes in your thinking, behavior, personality, or mood? If so, please describe:

____

____

Have you been receiving treatment to address your concerns? If so, has it been helpful? Please describe:

____

____

LEVEL OF DISTRESS

On a scale of 1 – 10, indicate how distressed you are with 10 being the highest level of distress: ______________

Are you currently experiencing any self-harming thoughts/behaviors? ☐ Yes ☐ No

Frequency: ____________ Intensity (1 – 10 Scale): _____ Duration (how many hours/days): ____________

Are you currently experiencing any suicidal thoughts? ☐ Yes ☐ No

Frequency: ____________ Intensity (1 – 10 Scale): _____ Duration (how many hours/days): ____________

Have you experienced either of them in the past? ☐ Yes ☐ No

If yes, explain: ____

Do you currently have a plan for self-harming? ☐ Yes ☐ No

If yes, explain: ____

Have you ever attempted suicide? ☐ Yes ☐ No

If yes, dates of attempt(s): ______________________________________

Describe attempt(s) and outcome(s): ________________________________

Counseling Specialists
OF CENTRAL FLORIDA

Is there a family history of self-harming and/or suicide attempts/gestures/completions? ☐ Yes ☐ No

If yes, describe, including relationship(s) to client: ______________________________

Are you currently experiencing any violent thoughts or have a history of destructive behaviors? ☐ Yes ☐ No

If yes, explain: ______________________________

Do you have a history of legal issues? ☐ Yes ☐ No

If yes, explain: ______________________________

Do you have a probation officer? ☐ Yes ☐ No

If yes, explain: ______________________________

PROTECTIVE FACTORS

- ☐ Religious beliefs
- ☐ Future focused
- ☐ Social support(s)
- ☐ Maintains positive relationships
- ☐ History of seeking help during crisis
- ☐ Frustration tolerance
- ☐ Absence of a plan, means, and/or intent
- ☐ Responsible for children and/or pets
- ☐ Willingness to engage in treatment
- ☐ Other information: ______________________________

RELIGIOUS BACKGROUND

Do you believe in God? ☐ Yes ☐ No Who or what provides you with strength and hope? ____________________

Have religious or spiritual beliefs been important in your life? ☐ Yes ☐ No

Do you attend a place of worship? ☐ Yes ☐ No

If yes, where: ______________________________ How often do you attend: ____________________

Did you have a religious upbringing? ☐ Yes ☐ No If so, how would you describe it: ______________________________

Who provides your support system? ______________________________ Any recent changes? ☐ Yes ☐ No

SYMPTOMS & CONCERNS

Please check each symptom that applies and add comments below as needed.

Attention & Concentration

- ☐ Difficulty paying attention to things
- ☐ Difficulty maintaining concentration
- ☐ Losing my train of thought easily
- ☐ Difficulty doing more than one thing at a time
- ☐ Feeling less alert or aware of things
- ☐ Difficulty following instructions or directions
- ☐ Being distracted by my own thoughts
- ☐ Being distracted by noises or the environment
- ☐ Having my mind go blank frequently
- ☐ Becoming easily confused and disoriented
- ☐ Tasks take more attention/effort than before
- ☐ Speed of thinking is slower than it used to

Problem Solving & Organization

- ☐ Difficulty solving problems that others could manage
- ☐ Difficulty figuring out how to do new things
- ☐ Difficulty completing an activity in a reasonable time
- ☐ Difficulty doing things in the right order (sequencing)
- ☐ Difficulty organizing items for a project
- ☐ Difficulty problem-solving in social situations
- ☐ Difficulty changing a plan/activity as needed
- ☐ Difficulty planning ahead
- ☐ Difficulty thinking as quickly as needed

Word Finding & Naming

- ☐ Difficulty finding the word I want to say
- ☐ Forgetting names of family/close friends
- ☐ Difficulty learning new names
- ☐ Using wrong words when speaking
- ☐ Forgetting names of acquaintances

Speech & Language

- ☐ Difficulty understanding what others say
- ☐ Difficulty getting my speech started
- ☐ Change in the complexity of my speech
- ☐ Change in the speed of my speech
- ☐ Change in the clarity of my speech
- ☐ Change in the volume of my speech

Memory

☐ Forget where I leave things (e.g. keys, phone, etc.)
☐ Forget why I walked into a room
☐ Forget things that happened hours or days ago
☐ Forget events that happened months or years ago
☐ Rely more on notes to remember things
☐ Forget facts but can remember how to do things
☐ Forget the content of conversation
☐ Getting lost while driving in familiar places
☐ Forget names
☐ Forget where I am or where I am going
☐ Forget appointments
☐ Rely more on others to remind me of things
☐ Forget how to do things
☐ Forget faces of people I know
☐ Forget if a conversation occurred
☐ Purchasing 6-7 items in a store without a list

Academic Skills

☐ Difficulty understanding what I read
☐ Difficulty retaining what I read
☐ Difficulty with spelling, grammar, or punctuation
☐ Difficulty with mental math
☐ Difficulty with paper and pencil math
☐ Difficulty managing my finances

Sensory Symptoms

☐ Near sighted
☐ Astigmatism
☐ Difficulty with night vision
☐ See things that are not there
☐ Color blindness
☐ Hearing loss
☐ Hear strange sounds
☐ Hearing aids: if so, since what age: _______
☐ Taste: Increased sensitivity
☐ Smell: Increased sensitivity
☐ Touch: Increased sensitivity, including texture(s)
☐ Far-sighted
☐ Blurred vision
☐ Double vision
☐ Poor peripheral vision
☐ Wear glasses: if so, since what age: _______
☐ Ringing in ears
☐ Hearing loss
☐ Taste: Decreased sensitivity
☐ Smell: Decreased sensitivity
☐ Touch: Decreased sensitivity, including texture(s)

Motor Symptoms

☐ Weakness on one side of body
☐ Fine motor difficulties
☐ Difficulty with balance
☐ Muscle weakness
☐ Tremor or shakiness
☐ Tic or strange movements
☐ Muscle stiffness
☐ Difficulty walking

Mood & Behavior

☐ Sadness or depression: if applicable, circle one	☐ Mild	☐ Moderate	☐ Severe
☐ Anxiety or nervousness: if applicable, circle one	☐ Mild	☐ Moderate	☐ Severe
☐ Anger: if applicable, circle one	☐ Mild	☐ Moderate	☐ Severe
☐ Oppositionality: if applicable, circle one	☐ Mild	☐ Moderate	☐ Severe
☐ Sleep problems: if applicable, circle one	☐ Failing asleep	☐ Staying asleep	☐ Both
☐ Appetite problems:	☐ Decreased	☐ Increased	☐ Restricting
☐ Weight problems:	☐ Loss	☐ Gain	☐ Binge/purge

ALCOHOL & SUBSTANCE USE/ABUSE

Do you currently drink alcohol? ☐ Yes ☐ No

Started drinking alcohol at age: ____________ Frequency of alcohol use: ____

Usual # of drinks at one time: _____ Preferred types of drinks: ____

Last drink was: _________________ If no longer drinking alcohol, date stopped: ___________________________________

☐ I can sometimes get into trouble after drinking (explain): ____

☐ Sometimes I have personality changes when I drink (explain): ____

☐ I sometimes black out after drinking (explain): ____

☐ I have been dependent on alcohol (explain): ____

Do you currently use drugs? ☐ Yes ☐ No

Started using drugs at age: _______ Frequency of drug use: ____________________________

If no longer using drugs, date stopped: ____________________ I have been in drug treatment: ☐ Yes ☐ No

Check all of the below drugs you are either currently using or have used in the past:

Cannabis:	☐ Presently Using	☐ Used in the Past
Hallucinogenics (LSD, mushrooms, etc.):	☐ Presently Using	☐ Used in the Past
Inhalants (glue, nitrous oxide, etc.):	☐ Presently Using	☐ Used in the Past
Stimulants (including cocaine, MDMA, diet pills):	☐ Presently Using	☐ Used in the Past
Opioids (oxycodone, fentanyl, heroin, methadone, etc.):	☐ Presently Using	☐ Used in the Past
Others: ______________________________________	☐ Presently Using	☐ Used in the Past

Are you currently, or have you previously been, dependent on any prescription drugs? ☐ Yes ☐ No

If yes, which ones: ____

Do you currently smoke cigarettes? ☐ Yes ☐ No

Started smoking at age: _________ Frequency of cigarette use: _____________ Amount per day: _______________

Last time I smoked was: _________________________ If you no longer smoke, date stopped: _____________________

Do you currently use vaping products? ☐ Yes ☐ No

Started vaping at age: ___________ Frequency of vaping use: ________________ Amount per day: _______________

Last time I vaped was: __________________________ If you no longer vape, date stopped: ______________________

Do you consume caffeinated drinks? ☐ Yes ☐ No

Amount per day: _______________ Types of caffeinated drinks consumed: ____________________________________

PSYCHOSOCIAL HISTORY

You were born: ☐ On time ☐ Prematurely ☐ Late ☐ Unknown

You were born through: ☐ Vaginal delivery ☐ Cesarean section ☐ Unknown

Were there any problems with your birth or early infancy? If so, describe:

____

As a child, did you have any of the following conditions:

☐ Attention problems	☐ Learning disability	☐ Speech problems
☐ Developmental delay	☐ Hearing problems	☐ Visual problems
☐ Hyperactivity/impulsivity	☐ Frequent ear infections	☐ Asthma
☐ Acting out behaviors	☐ Social difficulties	☐ Oppositional behaviors

FAMILY OF ORIGIN

Who lived in the household when you were growing up? ____

Is your mother alive? ☐ Yes ☐ No If no, cause of death: ____

Is your father alive? ☐ Yes ☐ No If no, cause of death: ____

Did your parents separate/divorce? ☐ Yes ☐ No If yes, please describe: ____

Did you have any step-parent(s)? ☐ Yes ☐ No If yes, please describe: ____

Were you adopted? ☐ Yes ☐ No If yes, please describe: ____

Additional Information:

____

____

Counseling Specialists
OF CENTRAL FLORIDA

List all familial relationships (except children) that are having or have had a positive or negative effect upon you:

Person's Name	M/F	Age	Alive	Mother, Father, Sibling, Aunt, etc.	Living at Home	Briefly Describe Him or Her

CHILDREN

List your children (living or deceased) that are natural born, legally guarded, fostered, adopted, or step:

Child's Name	M/F	Age	Grade	Natural, Step, Adopted, etc.	Living at Home	Briefly Describe Him or Her

Do any of these individuals have significant health concerns or special needs? ☐ Yes ☐ No

SIGNIFICANT FAMILY EVENTS

Have there been any significant events in your life (e.g. moves, divorce/custody, marriages, deaths, trauma, surgeries, etc.):

ABUSE HISTORY

Was there any abuse or neglect in the home growing up? ☐ Yes ☐ No

Were you a victim of any of the following types of abuse or witnessed any of the following? ☐ Yes ☐ No

☐ Physical Abuse ☐ Sexual Abuse ☐ Emotional Abuse ☐ Domestic Violence ☐ Neglect

Were you the victim, witness, or both? ______________________ Age at the time of abuse: _____ Length of abuse: ____________

Did you receive help/treatment? ☐ Yes ☐ No ☐ N/A Was it reported to the authorities? ☐ Yes ☐ No

Counseling Specialists
OF CENTRAL FLORIDA

SEXUAL INFORMATION

Has your sex drive been affected in any way? ☐ Yes ☐ No

If yes, explain: ____________________

Is your sexual orientation a problem for you or your family? ☐ Yes ☐ No

If yes, explain: ____________________

SOCIAL RELATIONSHIPS/SUPPORT SYSTEMS

Do you have at least one close friendship? ☐ Yes ☐ No

If yes, how many and who? ____________________

Do you currently have a support system? ☐ Yes ☐ No

If yes, whom does it include? ____________________

HOBBIES AND SPECIAL INTERESTS

Do you have any hobbies or special interests? ☐ Yes ☐ No

If yes, what are they? ____________________

MEDICAL HISTORY

List any food or medication allergies: ____________________

List any surgeries and year:

____

____

Sleep Pattern

☐ No known problems ☐ Difficulty falling asleep ☐ Early awakening ☐ Frequent nightly awakening
☐ Insomnia ☐ Hypersomnia ☐ Interrupted Sleep: if yes # of interruptions per night: ________
☐ Nightmares/terrors ☐ Sleep apnea ☐ Sleep study: if yes, approximate date: ____________

Neurological

☐ No known problems ☐ Seizure ☐ Tinnitus ☐ Headaches
☐ Tremors ☐ Stroke ☐ Paralysis ☐ Head injury
☐ Right side weakness ☐ Left side weakness ☐ Dystonia ☐ Unsteady gait
☐ Tardive dyskinesia ☐ Paresthesia ☐ Akathisia ☐ Other: ____________

Cardiovascular

☐ No known problems ☐ Edema ☐ Heart surgery ☐ Palpitations
☐ Congenital defects ☐ Hypertension ☐ Hypotension ☐ Angina
☐ Arrhythmia ☐ Chest pain ☐ Heart attack (MI) ☐ Clotting problems
☐ Mitral Valve Issues ☐ Pulmonary Stenosis ☐ Other heart/vascular issues: ____________

Respiratory

☐ No known problems ☐ Non-smoker ☐ Asthma ☐ Dyspnea
☐ Cough ☐ Productive cough ☐ COPD ☐ Smoker

Gastrointestinal

☐ No known problems ☐ GERD ☐ Ulcer ☐ IBS
☐ Constipation ☐ Diarrhea ☐ Nausea ☐ Vomiting
☐ Difficulty chewing ☐ Hemorrhoids ☐ Liver disease ☐ Gall bladder disease

Endocrine

☐ No known problems ☐ Adrenal ☐ Thyroid ☐ Pituitary
☐ Diabetes Type I ☐ Diabetes Type II ☐ Osteoporosis ☐ Other: ____________

Counseling Specialists
OF CENTRAL FLORIDA

Urinary

☐ No known problems ☐ Infection ☐ Urgency ☐ Hematuria
☐ Burning ☐ Discharge ☐ Nycturia ☐ Frequency
☐ Hesitancy ☐ Incontinence ☐ Prostate disease ☐ Other: ____________________

Reproductive

☐ No known problems ☐ Sexually active ☐ Unprotected sex ☐ Use birth control
☐ Endometriosis ☐ Infertility ☐ Hx of abortion ☐ Hx of miscarriage(s)
☐ PCOS ☐ Post-menopausal ☐ Vaginismus ☐ Vulvodynia
☐ Vestibulodynia ☐ Erectile dysfunction ☐ Premature ejaculation ☐ Other: ____________________

Infectious Disease

☐ No known problems ☐ AIDS/HIV ☐ Hepatitis ☐ Herpes
☐ Syphilis ☐ Chlamydia ☐ Gonorrhea ☐ Other STD: ________________
☐ Chicken pox ☐ Shingles ☐ Mononucleosis ☐ MRSA

Muscular-Skeletal

☐ No known problems ☐ Stiffness ☐ Fracture ☐ Arthritis
☐ Spasms ☐ Deformities ☐ Scoliosis ☐ Other: ____________________

Please provide any additional information that you feel is relevant to this assessment, including any forms of cancer:

____

____

MEDICAL PROVIDERS

List all doctors, hospitals, counselors, or residential/in-patient care you have received treatment from:

Name: ________________________________ Reason: ____

Name: ________________________________ Reason: ____

Name: ________________________________ Reason: ____

Name: ________________________________ Reason: ____

MEDICATIONS/SUPPLEMENTS

Name, dosage, frequency, problem: ____

Name, dosage, frequency, problem: ____

Name, dosage, frequency, problem: ____

Name, dosage, frequency, problem: ____

Name, dosage, frequency, problem: ____

Name, dosage, frequency, problem: ____

Name, dosage, frequency, problem: ____

Name, dosage, frequency, problem: ____

Name, dosage, frequency, problem: ____

PAIN ASSESSMENT

Do you currently have any pain? ☐ Yes ☐ No Frequency: ____________________ Intensity (1-10): __________

Where is your pain located? ____

What causes/increases the pain? ____

What decreases/relieves the pain? ____

Counseling Specialists
OF CENTRAL FLORIDA

CURRENT STATUS

Please check any of the following problems that apply to either you or your family:

Weight loss/gain:	☐ You	☐ Family	Self-esteem issues:	☐ You	☐ Family
Eating disorder(s):	☐ You	☐ Family	Hyperactivity:	☐ You	☐ Family
Stress/anxiety:	☐ You	☐ Family	Racing thoughts:	☐ You	☐ Family
Nervousness/panic:	☐ You	☐ Family	Unwanted thoughts:	☐ You	☐ Family
Fear/phobia(s):	☐ You	☐ Family	Hallucinations:	☐ You	☐ Family
Dreams/nightmares:	☐ You	☐ Family	Impulse control:	☐ You	☐ Family
Sleep problems:	☐ You	☐ Family	Obsessions/compulsions:	☐ You	☐ Family
Mood swings:	☐ You	☐ Family	Sexual acting out:	☐ You	☐ Family
Withdrawal/isolation:	☐ You	☐ Family	Pornography:	☐ You	☐ Family
Depression:	☐ You	☐ Family	Infidelity:	☐ You	☐ Family
Apathy/lethargy:	☐ You	☐ Family	Anger:	☐ You	☐ Family
Hope/helplessness	☐ You	☐ Family	Aggression:	☐ You	☐ Family
Grief/loss:	☐ You	☐ Family	Spiritual abuse:	☐ You	☐ Family
Terminal illness:	☐ You	☐ Family	Rape/incest:	☐ You	☐ Family
Loneliness:	☐ You	☐ Family	PTSD/trauma	☐ You	☐ Family
Shyness:	☐ You	☐ Family	Guilt/shame:	☐ You	☐ Family
Inferiority feelings:	☐ You	☐ Family	Communication:	☐ You	☐ Family

ADDITIONAL INFORMATION

Please provide any additional information that you feel is relevant to this assessment:

SIGNATURE SECTION

_______________________________________   _________________________
Signature of Client or Legal Guardian   Date

_______________________________________   _________________________
Printed Name of Client or Legal Guardian   Relationship to the Client