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?

_____

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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): _____

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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

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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): _____

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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:

_____

_____

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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

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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: _____

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Urinary

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

Reproductive

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

Infectious Disease

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

Muscular-Skeletal

- ☐ No known problems
- ☐ Spasms
- ☐ Stiffness
- ☐ Deformities
- ☐ Fracture
- ☐ Scoliosis
- ☐ Arthritis
- ☐ 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? _____

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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