ADULT QUESTIONNAIRE

The information you provide will help in the planning of your counseling and assist you and me in clarifying your therapy goals.

Client Name:_____ Date:_____

Birth date: _____/_____/_____ Age:_____ Gender: Female_____ Male _____ Transgender_____

Occupation:

1. What is your occupation presently?_____
2. Currently employed? ___Yes ___No If not, last date of employment:_____
3. If so, place of employment?_____
4. Length of time?_____

Academic Background:

1. Where did you attend high school?_____
2. Did you graduate? ___Yes ___No Year:_____
3. Did you attend college/professional school? ___Yes ___No
   If so, name of institution(s), degree(s) earned and year(s) graduated?_____
   _____
4. Any plans to further your education? ___Yes ___No
   If so, when and what will you study?_____

Cultural Background:

1. What is your **ethic identity**?
   ___African/African American ___Asian American/ Chinese/ Filipino/ Japanese/ Korean/ Vietnamese
   ___East Indian/Pakistani ___Latino/ Hispanic/ Mexican-American/ Puerto Rican
   ___Middle Eastern ___Native American/ Alaskan Native ___Polynesian/Micronesian
   ___White/Caucasian ___Other (specify)_____
2. How much do you identify with your **ethnic heritage**? (Check one):
   ___Not at all ___A little ___Somewhat ___Moderately ___Strongly
3. **Religious/Spiritual preference:**_____
   Do you consider yourself a religious person? ___Yes ___No or spiritual person? ___Yes ___No
   Comment: _____
   Faith: Group/Denomination in which you were raised:_____
   Current Congregation: _____
   How active are you? _____Inactive _____ Slightly _____ Moderate _____Very
4. Does your family **speak a language** other than English at home? (Check one):
   ___Not at all ___Very little ___Sometimes ___Frequently ___Always
   If "Sometimes" to "Always", what language is spoken_____
5. Were you and both your biological parents **born in the USA**? ___Yes ___No ___Unsure
   If no, who was foreign-born, where and what was the approximate age of immigration to the USA? (e.g., myself, Korea, 12; father Korea, 40;etc.):_____
6. Were you adopted: ? ___Yes ___No

Problem Analysis:

1. Have you **seen another therapist** in the past twelve months? ___Yes ___No
   If yes, who did you see? _____

2. Have you **seen another therapist** in the past 3 years? ___Yes ___No

   If yes, who did you see?_____

3. Have you **ever been hospitalized** for psychological/emotional difficulties? ___Yes ___No

   If yes, explain difficulty, dates hospitalized & type of medication _____

PROBLEM DESCRIPTION: Briefly **describe the problem** you most wish help with right now:_____

4. PROBLEM INTENSITY: How would you **rate the intensity** of the problem or concern that brought you in? (Circle the appropriate number):

1	2	3	4	5	6
Not intense		Moderately Intense			Extremely Intense

5. PROBLEM DURATION: Approximately **how long** have you had the current problem:_____

6. COPING ATTEMPTS: In what ways have you **attempted to cope** with this problem:_____

7. EXPECTATIONS: What do you **hope to accomplish** by coming here?_____

Family Background:

1. Family Mental Health History: In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Attempted/Completed Suicide (please circle)	yes/no	

2. Have you been **married/partnered before**? ___Yes ___No If yes, when and for how long?_____

3. Please list the names of your **children** or dependants.

Names of Children/Dependants	Date of Birth	Age	Lives With You? (please circle) Yes No

_____	_____	_____	Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No

4. List **others who may live with you** including their ages and occupations (e.g., brother 19, student; friend 35, teacher; etc.):

_____

_____

5. Please check any past, present, or impending **special problems in your family**:

___deaths	___divorce	___frequent relocations
___serious illness	___debilitating injuries/disabilities	___physical/sexual abuse
___legal problems	___financial crisis/unemployment	___other

6. Please specify **family member(s), with special problems**, and approximate year of occurrence (e.g., mother, serious illness, 1998; etc.):

_____

_____

_____

7. Would you like **anyone else** involved in the counseling with you? (family members, friends, etc):_____

_____

8. Is there a concern about **violence** in your life today? Either from you or towards you? Please explain:_____

_____

If yes, how concerned are you on a scale of 1 to 10, with 10 being the worst? (Circle one):

1 2 3 4 5 6 7 8 9 10

9. Have you personally experienced significant **family abuse**?

___none ___unsure ___emotional ___physical ___sexual

10. Have you personally experienced **legal problems**? ___NO ___YES

11. Did you experience **learning problems** in elementary or high school? (Check one):

___none ___little ___some ___substantial ___lots, constant struggle

12. In general, how **happy or adjusted** were you growing up? (Check one):

___poor ___unsatisfactory ___about average ___substantial ___completely

13. How much is your immediate family a source of **emotional support** for you? (Check one):

__none ___little ___somewhat ___substantial ___very strong

14. How much **conflict in values** do you currently experience with your parents? (Check one):

___very little or none ___some ___moderate ___strong ___extreme

15. Who in your family do you currently **feel closest** to?_____

Most **distant** from?_____ In most **conflict** with?_____

16. If you are married or in a long-term relationship, are you currently **in the process of divorce or separation**? Please specify:

If separated, what is the length of time apart?_____

If you have children, what reason(s) have you given them for the current problem?_____

How committed are you to making your relationship work?_____

What changes are you willing to make for the sake of your/relationship?_____

17. Describe any concerns regarding **sexual or emotional intimacy** with your partner._____

18. Please list any **information that you believe will be helpful** for your therapist to know._____

Health and Social Issues:

1. How is your **physical health** at present? ___poor ___unsatisfactory ___satisfactory ___good ___very good

2. Please list any **persistent physical symptoms** or health concerns you may have (e.g., chronic pain, diabetes, headaches, etc.):

3. Are you presently taking any **prescribed or non-prescribed medication** (psychiatric or otherwise)? ___Yes ___No
   Please list medication(s) and dosage:_____

4. Are you having any problems with your **sleep habits**? ___Yes ___No
   If yes, check where applicable: ___sleeping too little ___sleeping too much ___poor quality sleep
   ___disturbing dreams ___other_____

5. How many times per week do you **exercise**?_____ For about how long each time?_____

6. Are you having any difficulty with **appetite or eating habits**? ___Yes ___No
   If yes, check where applicable: ___eating less ___eating more ___binging ___poor appetite
   ___making myself vomit ___significant weight change (last two months)

7. Do you regularly use **alcohol**? ___Yes ___No
   In a typical month, how often do you have 4 or more drinks in a 24 hour period?_____
   Do you consider your alcohol consumption a problem? ___Yes ___No ___Maybe
   Does anyone else in your life consider your alcohol consumption a problem? ___Yes ___No ___Maybe

8. How often do you engage in **recreational drug use**? ___daily ___weekly ___monthly ___rarely ___never
   Do you consider this drug use a problem? ___Yes ___No ___Maybe ___N/A

9. Do you have any problems or worries about **sexual functioning**? ___Yes ___No
   If yes, check where applicable: ___lack of desire ___performance problem ___sexual impulsiveness
   ___difficulties maintaining arousal ___worried about sexually transmitted disease
   ___other:_____

10. Have you ever experienced **sexual assault, unwanted sex or uncomfortable touching**?
    ___frequently ___a few times ___once ___never ___unsure

11. Have you had **suicidal thoughts** recently? ___frequently ___sometimes ___rarely ___never
    Have you had them in the past? ___frequently ___sometimes ___rarely ___never

12. Have you ever intentionally inflicted any harm upon yourself? ___Yes ___No ___Unsure

13. In the past, how would you rate the quality of your **peer relationships**?
    ___very poor ___unsatisfactory ___about average ___good ___excellent

14. Approximately how many **significant intimate relationships** (e.g., lasting at least 6 months) have you been involved in?_____

15. Besides family members, approximately how many people can you really count on right now for friendship or **emotional support**?

_____

Additional note you wish to share:

_____

_____

_____

_____

_____

_____

_____

If you were referred to me, whom do I have to thank for the referral?_____

PLEASE SIGN BELOW TO INDICATE THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT:

_____ _____
Signature of Client (or person acting for client) Date

_____ _____
Printed Name Relationship to client (if necessary)

ABOUT YOUR CONCERNS

Please check all the items below that you currently experience or with which you are having difficulty. Feel free to add any others at the bottom under "Other concerns or issues." You may add details as needed to clarify.

	Abortion		Grieving, mourning		Physical problems
	Abuse - emotional		Guilt		PMS
	Abuse - neglect		Headaches, pains		Poor self-care
	Abuse - sexual		Health, illness		Pornography use
	Adoption		Hearing voices		Procrastination
	Aggression		Hostility		Relationship problems
	Alcohol Use		Hyperactivity		Relaxation
	Ambition		Impulsive spending		Re-marriage
	Anger		Impulsiveness		Risk-taking
	Anxiety		Incest		Sadness
	Arguing		Indecision		School problems
	Attention problems		Inferiority feelings		Self abuse – burning
	Career concerns		Infertility		Self abuse – cutting
	Childhood issues		Inhibitions		Self abuse - other: _____
	Children – care of		Interpersonal conflicts		Self abuse – scratching
	Children - custody		Irresponsibility		Self abuse – pulling hair out
	Children - management		Irritability		Self-centeredness
	Choices I've made		Judgment problems		Self-control
	Chronic pain		Laziness		Self-esteem
	Codependence		Legal matters, charges, suits		Self-neglect, poor self-care
	Communication		Loneliness		Separation – legal or otherwise
	Compulsive spending		Loss of control		Sexual addiction
	Confusion		Losses		Sexual conflicts
	Constant conflicts		Loss of interest in activities		Sexual desire differences
	Crying		Loss of interest in sex		Sexual orientation – conflicts/questioning
	Deaths		Low energy		Shyness
	Debt		Low frustration tolerance		Smoking
	Decision making		Low income		Spirituality
	Dependence		Low mood		Step-parenting
	Depression		Marital conflict		Stress
	Distractibility		Marital distance		Stress-management
	Divorce, separation		Marital infidelity/affairs		Suicidal thoughts/passive ideations
	Domestic violence		Medical concerns		Suspiciousness
	Drug abuse – over the counter		Memory problems		Temper problems
	Drug abuse - prescription		Menopause		Tension / stress
	Drug abuse – street drugs		Menstrual problems		Thought disorganization
	Drug abuse - alcohol		Mixed feelings		Threats of violence
	Education		Mood swings		Tiredness
	Employment – lack of		Motivation		Tobacco use
	Employment - overdoing		Mourning		Unhappiness
	Employment problems		Nail-biting		Violence
	Employment - termination		Nervousness		Violence – victim of crime
	Emptiness		Nightmares		Weight and diet issues
	Exhaustion		Obsessions, compulsions		Withdrawal – isolating
	Failure		Outbursts		Work problems
	Fatigue, low energy		Oversensitive to criticism		Worry all the time
	Fears, phobia		Oversensitive to rejection		**Other concerns or issues:**
	Feelings of helplessness/hopeless		Overweight		
	Financial troubles		Panic or anxiety attacks		
	Friendship problems		Parenting		
	Gambling		Perfectionism		
	Gender identity conflicts		Pessimism		
	Goals not being met		Phobias		