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 ethnic identity?
   - ☐ African/African American
   - ☐ East Indian/Pakistani
   - ☐ Middle Eastern
   - ☐ White/Caucasian
   - ☐ Asian American/ Chinese/ Filipino/ Japanese/ Korean/ Vietnamese
   - ☐ Latino/ Hispanic/ Mexican-American/ Puerto Rican
   - ☐ Native American/ Alaskan Native
   - ☐ Polynesian/Micronesian
   - ☐ 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 ☐ Moderately ☐ 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? (Check the appropriate number):

☐ 1 Not intense ☐ 2 ☐ 3 ☐ 4 Moderately Intense ☐ 5 ☐ 6 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 Check	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	☐ yes/no ☐	

(please circle)

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 check)
_____	_____	____	☐ 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? (Check 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
   ☐

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 notes 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		