Innervisions Counseling & Consulting Center S.C.

840 State Road 136, Suite #1 in Baraboo, WI 53913
231 East State Street in Mauston, WI 53948
Phone (608) 477-9858 Fax (877) 560-0578

INTAKE QUESTIONNAIRE – ADULT

Your response to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.

Name of person completing form: _____ Date: _____

IDENTIFYING INFORMATION (for individual receiving services)

Name: _____ Date of Birth: _____

Address: _____ Sex: _____

_____ Marital Status: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Social Security Number: _____ Household Income: $ _____

Who referred you to Innervisions? _____

Race:

- ☐ White/Caucasian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Unknown
- ☐ Asian
- ☐ Black/African American
- ☐ Two or more races

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Non-Latino

Language of Choice:

- ☐ English
- ☐ Hmong
- ☐ Russian
- ☐ Laotian
- ☐ Spanish
- ☐ German
- ☐ French
- ☐ Other: _____

Religious Affiliation:

- ☐ Catholic
- ☐ Muslim
- ☐ Jewish
- ☐ Amish
- ☐ Mennonite
- ☐ Protestant (including Lutheran, Methodist, etc.)
- ☐ Non-Denominational
- ☐ No Affiliation
- ☐ Other: _____

Disability:

Do you have a disability? ☐ Yes ☐ No If yes, please specify: _____

If you have a disability, does the office accommodate your needs? ☐ Yes ☐ No

If no, please explain: _____

If you feel that the therapist should be aware of any special treatment considerations due to gender, age, sexual orientation or cultural, religious, national, racial or ethnic identity, please explain below:

_____

_____

_____

PRESENTING PROBLEM (current situation and history)

1. What is the primary problem for which you are seeking help? (please circle)

a. Marriage or relationship	g. Problems with children	m. Grieving
b. Family problems	h. Peer problems	n. Abuse or trauma
c. Depression	i. Eating disorder	o. Sexual functioning
d. Mood swings	j. Alcohol/drug use	p. Anger
e. Behavior	k. Physical problems	q. Anxiety or worry
f. Self-confidence	l. Work related	r. Other (explain):

_____

_____

_____

2. How long have you had this/these problem(s)? _____

3. Have you received treatment for this problem or any other problem in the past? ☐ Yes ☐ No

   If yes when, where and with whom? _____

   _____

SUICIDE RISK

Suicide risk: □ Denies □ Ideation □ Intent □ Plan □ Attempt
Notes:

Danger to others: □ Denies □ Ideation □ Intent □ Plan □ Attempt
Notes:

Past History of Suicide Risk: _____
_____
_____

Current/Recent Suicide Risk:_____
_____
_____

FAMILY HISTORY

1. Were drugs or alcohol a problem in your family when you were growing up? ☐ Yes ☐ No
   If yes, please explain: _____
   _____

2. Do you or another family member have a history of alcohol or drug problem? ☐ Yes ☐ No
   If yes, please explain: _____
   _____

3. Please describe your current alcohol consumption: _____
   _____

4. Was there any type of abuse (physical, sexual, domestic or emotional) in your family or home?
   ☐ Yes ☐ No If yes, please describe the circumstances: _____
   _____

5. Have you or any other family member experienced any type of abuse? ☐ Yes ☐ No
   If yes, please explain: _____
   _____

LEGAL HISTORY

Please describe any involvement you have had with the legal system (arrests, convictions, probation and parole):

_____

_____

CURRENT FAMILY INFORMATION

1. Please provide the following information:

Name (First and Last)	**Date of Birth**	**Lives with You?**
Spouse/Significant Other:		Yes No
Children: _____		Yes No
_____		Yes No
_____		Yes No
_____		Yes No

Others Living in Household:		

2. Highest educational level achieved: _____

3. Military service: ☐ Yes ☐ No

4. Occupation: _____

5. Current employer: _____

MEDICAL HISTORY

1. Primary Care physician/pediatrician: _____

2. Would you like Innervisions to coordinate care with your PCP? ☐Yes ☐ No
If yes, you will need to fill out a release of information for your PCP.

3. Please check the appropriate box if you have experienced any of these problems:

☐ Eye disease, injury, poor vision
☐ Ear disease, injury, poor hearing
☐ Nose, sinus, mouth, throat problems
☐ Head injury
☐ Convulsions or seizures
☐ Memory problems
☐ Extreme tiredness or weakness
☐ Thyroid disease or goiter
☐ Skin disease
☐ Heart disease
☐ Back, arm, leg or joint problems
☐ Blood disease
☐ Stomach problems
☐ Premenstrual Syndrome (PMS)
☐ Eating disorder
☐ Liver, gallbladder disease
☐ Chest pain or angina pectoris
☐ Cancer
☐ Bowel problems
☐ Hemorrhoids, rectal bleeding
☐ Loss of consciousness
☐ Frequent or severe headaches
☐ Sleep disturbances
☐ Neck stiffness, pain, swelling
☐ Marked weight changes
☐ Circulatory problems
☐ Allergies or asthma
☐ Diabetes
☐ Encephalitis
☐ Meningitis
☐ Pregnancy not carried to term/stillbirths
☐ High blood pressure
☐ Other _____

Please explain anything checked above: _____

_____

3. Please provide information about medication(s), prescription or over-the-counter, which you take regularly:

Medication	Dosage/Frequency	Prescribing Physician	For what condition?

4. Please list significant hospitalizations, operations, injuries (including broken bones): _____

_____

GOALS

1. What are your strengths? _____

_____

2. What are your weaknesses? _____

_____

3. What goals would you like to see reached as a result of your involvement with *[Your Organization's Name]*?

_____

_____

_____

_____

4. How will you know when these goals have been reached?

_____

_____

_____

THERAPIST REVIEW

Signature: _____ Date: _____