Innervisions Counseling & Consulting Center S.C.

840 State Road 136, Suite #1, Baraboo WI 53913

231 East State Street, 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.*

| IDENTIFYING INFORMATION *(for individual receiving services)* | | | | | |
| --- | --- | --- | --- | --- | --- |
| Name: |  | |  | Date of Birth: |  |
| Street Address: |  | |  | Sex: |  |
| City/State/Zip: |  | |  | Marital Status: |  |
| Home Phone: |  | |  | Cell Phone: |  |
| SSN: |  | |  | Household Income: |  |
|  |  | |  | Preferred Pronouns: | He/His/Him  She/Hers/Her |
| 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?  No  Yes   * If yes, please specify: |
| If you have a disability, does the office accommodate your needs?  No  Yes |
| * 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)*: | | | |
| --- | --- | --- | --- |
| What is the primary problem for which you are seeking help? | | | |
| Marriage or relationship  Family problems  Depression  Mood Swings  Behavior  Self-confidence | Problems with children  Peer problems  Eating disorder  Alcohol/drug use  Physical problems  Work related | Grieving  Abuse or trauma  Sexual functioning  Anger  Anxiety or worry  Other *(explain below)*: | |
|  | | | |
| How long have you had this/these problems *(indicate below)*? | | | |
|  | | | |
| Have you received treatment for this problem or any other problem in the past? | | | No  Yes |
| * 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: | |
| --- | --- |
| Were drugs or alcohol a problem in your family when you were growing up? | No  Yes |
| * If yes, please explain: | |
| Do you or another family member have a history of alcohol or drug problem? | No  Yes |
| * If yes, please explain: | |
| Please describe your current alcohol consumption: | |
| Was there any type of abuse *(physical, sexual, domestic or emotional)* in your family or home? | No  Yes |
| * If yes, please describe the circumstances: | |
| Have you or any other family member experienced any type of abuse? | No  Yes |
| * 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: | | | | |
| --- | --- | --- | --- | --- |
| Please provide the following information: | | | | |
|  | **Name (First and Last)** | | **Date of Birth** | **Lives with you?** |
| Spouse/  Significant Other: |  | |  | No  Yes |
| Child: |  | |  | No  Yes |
| Child: |  | |  | No  Yes |
| Child: |  | |  | No  Yes |
| Child: |  | |  | No  Yes |
| Child: |  | |  | No  Yes |
| Other (specify): |  | |  | No  Yes |
| Other (specify): |  | |  | No  Yes |
| Highest educational level achieved: | |  | | |
| Military service: | | No  Yes | | |
| Occupation: | |  | | |
| Current employer: | |  | | |

| MEDICAL HISTORY: | | | | |
| --- | --- | --- | --- | --- |
| Primary Care physician/pediatrician: | |  | | |
| Would you like Innervisions to coordinate care with your PCP? | | No  Yes - *(if yes, you will need to fill out a release of information for your PCP)* | | |
| Please check the appropriate box *(below)* 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 no carried to term/stillbirths  High blood pressure  Other: | |
| Please explain anything checked above: | | | | |
| Please provide information about medication(s), prescription or over the counter, which you take regularly: | | | | |
| Medication | Dosage/Frequency | | Prescribing Physician | For what condition? |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
| Please list significant hospitalizations, operations, injuries (including broken bones): | | | | |

| GOALS: |
| --- |
| What are your strengths? |
| What are your weaknesses? |
| What goals would you like to see reached as a result of your involvement with Innervisions Counseling? |
| How will you know when these goals have been reached? |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **THERAPIST REVIEW:** | | | | |
| Signature: |  |  | Date: |  |
|  |  |  |  |  |