Breaking Free Services
Center for Wellness
Treating Mind, Body & Spirit

Adult Intake Questionnaire

Client Name: _____ Date of Birth: _____

Prior to beginning therapy with us, we request that all of clients complete this form. The questions are designed to help clarify the changes you want to make in your life, and the expectations you have of the following counseling relationship, as well as to provide important background information so that we can have a better understanding of your experience. Please give these questions serious consideration.

1. What challenges in your life would you like to overcome?

_____

_____

2. Rewrite the above list from most important (#1) to least important (#10):

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

3. What are some of your self-defeating behaviors? That is, what do you do that seems to make things worse, or just doesn't seem to help you?

_____

_____

4. What are your strengths? What are your passions and interests? What do you like about yourself? Who or what in your life acts as a support for you?

_____

_____

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Background Information

Who lives with you? How is your relationship with them? _____

_____

Do you currently have any housing, work-related, or daily living activities (e.g. transportation)? _____

_____

Do you currently have any legal or financial stressors? _____

_____

Have you ever been incarcerated? If so, when? _____

How far did you go in school? _____

Were you raised in and do you currently practice any religion? _____

_____

Do you have any history of cruelty to animals, wetting the bed, or setting things on fire? _____

_____

Are you currently in a romantic relationship? Do you feel safe & supported in this relationship? _____

_____

Have you ever been a victim of physical/sexual/emotional abuse? ( ) Yes ( ) No ( ) Prefer not to say at this time

Have you experienced any other traumatic events in your life? (car accidents, fires, combat zones, etc.) _____

_____

Have you ever participated in mental health treatment before? Please list dates, duration, location, reason, & whether it was inpatient or outpatient.

_____

_____

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Have you ever been given any mental health diagnoses? Please list. _____

_____

Do you currently use or have you ever used any substances (e.g. alcohol, marijuana, cocaine, etc.)? Please list substance, frequency, and estimated date of last use.

_____

_____

Please check any of the following of which you had in the past or are now experiencing:

Problem	*Past*	*Present*	*Problem*	*Past*	*Present*	*Problem*	*Past*	*Present*
Blurred Vision			Back Pain			Loss of Consciousness		
Chest Pain			Diabetes			Jaundice		
Double Vision			Hearing Loss			Shortness of Breath		
Blackouts			Sleeping More			Blood in Bowel Movement		
Severe Headaches			Sleeping Less			Heart Attack		
Seizures			Mood Swings			Tuberculosis		
Dizzy Spells			Compulsions			Smokers' Cough		
Hepatitis			Confusion			Kidney/Urine Infection		
Vomited Blood			Excessive Blood Loss			Sexually Transmitted Disease		
Pneumonia			Stomach Pains			Blood in Urine		
Swollen Ankles			Bruise Easily			Menstrual Difficulties		
Venereal Disease			Reactions to Medications			Weakness in Arms & Legs		
Broken Bones			Sinus/Frequent Colds			Blood Transfusions		
Weight Gain			Appetite Changes			Weight Loss		

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Females Only: Any discontinued pregnancies? ( ) Yes ( ) No If yes, how many? _____
Full term pregnancies? ( ) Yes ( ) No If yes, how many? _____

Has anyone in your family (parents, brothers, sisters, cousins, aunts, uncles) had any of the following? *Check any that apply.*
( ) Kidney Disease ( ) Tuberculosis ( ) Heart Disease ( ) Mental Illness ( ) Cancer ( ) Drug/Alcohol Abuse
( ) Tumors ( ) Epilepsy ( ) Diabetes ( ) Nervous Disorders

Please answer the following statements by how you feel:

Statement	*Strongly Disagree*	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*
I am satisfied with my life					
I feel good about myself					
I am happy with the way I look					
I have a good relationship with my family					
I have supportive friends					
My health is good					
I experience little physical pain					
I have adequate physical strength					
I enjoy my leisure time					
I am happy with my job/work					

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The following items concerns feelings you may have had during the last month.

Statement	*Strongly Disagree*	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*
I have a feeling of hopelessness about the future					
I feel worthless					
I feel blue					
I feel weak in parts of my body					
My heart pounds and races					
I have urges to beat, injure or harm someone					
I feel that I am watched or talked about by others					
I have to avoid certain things, places, or situations because they frustrate me					

The following items describe difficult or stressful situations you may have experienced during the last month.

Statement	*Strongly Disagree*	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*
I have recently had a physical fight with someone					
I have recently tried to harm myself or had a plan to					
I have recently become upset or angry					
I have recently broken things or destroyed property					
I am able to get around the community on my own					
I can get help when I need it					
I take care of my home and living space					
I am functioning well at my work/school					