899 Logan Street, Suite 307
Denver, CO 80203
(303) 756 1197

# ADULT INTAKE QUESTIONNAIRE

**Client Information**

Name: _____

Date of Birth: _____ Age: _____

Preferred Title:

- ❑ Dr.
- ❑ Mrs.
- ❑ Mr.
- ❑ Ms.
- ❑ _____

Sex at Birth:

- ❑ Male
- ❑ Female
- ❑ Intersex
- ❑ _____

Gender:

- ❑ Male
- ❑ Female
- ❑ Trans- Female
- ❑ Trans-Male
- ❑ Agender
- ❑ Non-binary
- ❑ Gender Queer
- ❑ Gender Questioning
- ❑ _____

Address: _____

_____

Relevant Phone #'s: _____

Relevant Email: _____

(include cell numbers, work numbers, emails, or wherever is easiest to reach you)
Describe any confidentiality considerations you would like us to take when using the above contact numbers:

Referred by: _____
We often thank referrals for sending you my way. Is this okay with you? _____
(This only applies to other providers- not friends or past clients)

**Emergency Contacts**
Name of one or more emergency contacts and relationship(s) to you:

_____

Phone #'s: _____

**Insurance Information**

If you plan to use your insurance to get reimbursed for services, please complete the information below.

*Primary Insurance Information:*
Insurance Company Name: _____ID #: _____ Group #_____

Policy Holder Name: _____Policy Holder DOB: _____Policy Holder SS #: _____

*Secondary Insurance Information:*
Insurance Company Name: _____ID #: _____ Group #_____

Policy Holder Name: _____Policy Holder DOB: _____Policy Holder SS #: _____

**Family History and Cultural Information** **Office Use Only**

Please list all member's living in your home and the relationship to you.

| Name | Gender | Age | Relationship |
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How would you describe the relationship between you and your housemates?

How would you describe your religious values? Please describe:

What cultural/ethnic group do you identify with? _____
What does your affiliation with this group mean to you?

Languages spoken within the home?
Your primary language:
Your secondary language:

Any additional information pertaining to language acquisition/exposure including dual-language schools/family history?

## Current Concerns

**Office Use Only**

| Please describe the primary concerns or goals you have for this assessment: | |
|---|---|
| Concern/goal #1 | |
| Concern/goal #2 | |
| Concern/goal #3 | |
| What steps have you taken to address these concerns in the past? What has worked? What has not worked? | |
| What prompted you to seek services now? | |

## Developmental Section

**Office Use Only**

| **Birth History:** | |
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| Weeks gestation _____<br>Drugs/ medications used by mother during pregnancy?<br>_____<br>Complications? _____<br>_____<br>Condition at birth? _____<br>Other relevant information? _____ | |

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| How would you describe yourself as a child or adolescent? | |
| Please provide information regarding your development by providing the approximate age when each of the following was achieved independently. (If possible, you may need to discuss with a parent/guardian).<br><br>Rolled over _____<br>Sat up _____<br>Stood up _____<br>Crawled _____<br>Walked _____<br>Spoke first words_____ What were they? _____<br>Put two words together _____<br>Demonstrated understanding of simple directions _____<br>Read words _____<br>Wrote words _____<br>Used a crayon to color _____<br>Was toilet trained during the day _____<br>Was toilet trained at night _____<br>Made eye contact with others_____<br>Engaged in interactive play_____<br>Identified someone as a best friend _____<br>Started showing physical signs of puberty _____ | |
| Have you ever shown a regression in developmental skills or lost a skill once you acquired it? If so please describe. | |
| Do you demonstrate any repetitive behaviors? If so please describe. | |
| Do you regularly integrate nonverbal means of communication such as nodding, gestures, eye contact, and varied facial expressions? | |
| Do you have any difficulties with attention, concentration, or hyperactivity? If so, when did these problems first arise? | |

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| Has anyone in your family ever been diagnosed with a developmental disorder or developmental delay? | |

**Physical Health** **Office Use Only**

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| Please list any major physical illnesses, accidents, hospitalizations, and surgeries in your medical history along with dates and ages. | |
| List all major or chronic illnesses with dates and ages _____<br>_____<br>_____<br>Still experiencing symptoms? _____<br>Lasting effects? _____ | |
| Please describe any major accidents or falls along with dates and ages____<br>_____<br>_____<br>Did any result in a head injury or concussion? _____<br>Any changes in behavior or cognitions following the injury? _____<br>If so please describe changes and duration. _____<br>_____ | |
| Please describe any hospitalizations and/or major surgeries along with dates and ages<br>_____<br>Any lasting problems or pain? _____ | |
| Are you currently experiencing any chronic pain? If so, please describe the pain, intensity, duration, and cause. | |

Please provide information regarding any current or past medications that you have taken for an extended period of time. It is especially important to include all medications that are related to your current concerns.

| Medication | Dates taken | Dosage | Purpose | Effective? |
|---|---|---|---|---|
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Name of current prescribing physician or psychiatrist_____

How many hours of sleep do you get per night? _____
Describe any difficulties with sleep:

How would you describe your eating habits?

Any recent weight gains/losses not related to growth?

How do you feel about your weight?

Describe your attitude toward and involvement in physical exercise:

How do you feel about your physical condition?

Are there any concerns for your vision or hearing? If so, describe:

Do you have any difficulties with motor skills or coordination? If so describe:

Do you have any sensory sensitivities? Is there excessive avoidance of some sensory stimulation or any excessive sensory seeking behaviors? If so, please describe:

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| Do you use drugs, alcohol, or cigarettes? If so, please describe the frequency of use. | |

**Social** **Office Use Only**

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| How would you describe your friendships, including the quantity and quality of these relationships? | |
| Do you have difficulty making or keeping friends? If so, describe these difficulties. | |
| How do you spend social time? What kinds of activities do you enjoy? What do you do for fun (e.g. hobbies, interests)? | |

**Psychological** **Office Use Only**

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| Have you ever been diagnosed with a mental health disorder? If so, please describe current symptoms. | |
| Have you ever had psychological testing completed? If so, describe results and include the person/agency who conducted the testing. | |
| Has anyone in your family ever been diagnosed with a mental health disorder? Please indicate family member and diagnosis. | |
| Describe any past therapy experiences (include dates). What worked or didn't work? | |
| Have you ever been psychiatrically hospitalized? (If yes, where and when?): | |

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| Please describe your typical mood: | |
| Please describe your personal strengths: | |
| Please circle any of the following that you have experienced in the last 6 months:<br><br>Increased/decreased appetite — Lack of energy/lethargy<br>Isolating from others — Repetitive behavior<br>Loss of Interest — Relationship issues<br>Feeling empty — Recurring thoughts<br>Hopelessness — Extreme worry<br>Crying spells — Nightmares<br>Increased fears — Flashbacks<br>Sleep problems — Too much energy<br>Short attention span — Trouble concentrating<br>Increased anger — Sexual issues<br>Abuse of alcohol/drugs — Memory problems<br>Feeling paranoid — Racing thoughts<br>Increased irritability — Mood swings<br>Nervousness — Violent actions<br>Panic attacks — Change in weight<br>Easily frustrated — Feeling stressed<br>Low self-esteem — Depressed mood<br>Anxiety — Unusual/extreme euphoria<br>Increased fatigue — Recklessness<br>Self-hate — Procrastination<br>Confusion — Hearing voices that others don't<br>Seeing things that others don't — Disorientation | |
| Do you feel that you experience difficulties with coping skills?<br><br>Please describe things that you do to cope with stressors? | |

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| Have you ever engaged in self-harm such as cutting, head banging, or any other purposeful injury to self? | |
| Do you feel that you have a difficult time controlling your anger?<br><br>Have you ever become violent with another person? If so, when and what situation? | |
| Have you ever spent time in jail, prison, or detention? If so, when and for what crime? | |
| Have you had any suicidal thoughts or attempted suicide in the last six months? | |
| Have you ever attempted suicide? | |

**Education and Occupation** **Office Use Only**

| | |
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| What is your current school or employment setting?<br><br>What is your current position?<br><br>How would you describe your experience in school? | |
| Is there a history of learning problems? If so, describe: | |
| Have you had any previous educational testing? (through tutoring centers, school, Child Find or early intervention)? Have you ever been supported via an IEP or 504 Plan? If yes, please describe the type of testing, accommodations/interventions (formal and informal) received:<br><br>Diagnosis?<br><br>What recommendations were made as a result of the evaluation? | |
| Has anyone in your family been diagnosed with a learning disability or other disability that affects learning? | |

| **Environmental** | **Office Use Only** |
|---|---|
| Describe any environmental trauma you may have experienced (e.g., tornados, floods, hurricanes, etc.): | |
| Describe any sexual/physical/mental abuse: | |
| Have you ever been the victim of a violent crime? If so describe: | |
| Please describe any significant environmental stressors that have affected you. | |

We have asked you a lot of questions, however, is there any additional information that you feel would be important to add?

Please sign below to indicate that the above information is accurate to the best of your knowledge.

Client _____ Date_____