

# ***Innervisions Counseling & Consulting Center S.C.***

840 State Road 136, Suite #1 in Baraboo, WI 53913  
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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: \$ \_\_\_\_\_

Preferred Pronouns: He/His/Him or She/Hers/Her

Who referred you to Innervisions? \_\_\_\_\_

#### **Race:**

- |  |   |
|--|---|
| <input type="checkbox"/> White/Caucasian                     | <input type="checkbox"/> Asian                  |
| <input type="checkbox"/> American Indian or Alaska Native    | <input type="checkbox"/> Black/African American |
| <input type="checkbox"/> Native Hawaiian or Pacific Islander | <input type="checkbox"/> Two or more races      |
| <input type="checkbox"/> Unknown                             |   |

#### **Ethnicity:**

- Hispanic or Latino  
 Non-Hispanic or Non-Latino

#### **Language of Choice:**

- |                                  |                                       |
|----------------------------------|---------------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Spanish      |
| <input type="checkbox"/> Hmong   | <input type="checkbox"/> German       |
| <input type="checkbox"/> Russian | <input type="checkbox"/> French       |
| <input type="checkbox"/> Laotian | <input type="checkbox"/> Other: _____ |

#### **Religious Affiliation:**

- |                                    |   |
|------------------------------------|---|
| <input type="checkbox"/> Catholic  | <input type="checkbox"/> Protestant (including Lutheran, Methodist, etc.) |
| <input type="checkbox"/> Muslim    | <input type="checkbox"/> Non-Denominational                               |
| <input type="checkbox"/> Jewish    | <input type="checkbox"/> No Affiliation                                   |
| <input type="checkbox"/> Amish     | <input type="checkbox"/> Other: _____                                     |
| <input type="checkbox"/> Mennonite |   |

#### **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:

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**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):   |

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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? \_\_\_\_\_

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**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:

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

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

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**GOALS**

1. What are your strengths? \_\_\_\_\_

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2. What are your weaknesses? \_\_\_\_\_

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

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

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**THERAPIST REVIEW**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_