

# Diana L. Saunders, MA, LPC

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## CLIENT INFORMATION

Client Name: \_\_\_\_\_ Sex:  Male  Female  TransG  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_  
Please Indicate:  Single  Married  Separated  Divorced  Widowed  Student  Preschool child  
Home Address: \_\_\_\_\_  
Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer (School, if student): \_\_\_\_\_ Work/School Phone: (\_\_\_\_\_) \_\_\_\_\_  
Employer/School Address: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ Fax Phone: (\_\_\_\_\_) \_\_\_\_\_

## **C and/or SPOUSE'S INFORMATION**

Responsible Party: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
Please Indicate:  Single  Married  Separated  Divorced  Widowed  Student  
Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Address: \_\_\_\_\_

**PAYMENT POLICY:** Payment for services is required at the time they are rendered. Payment may be made by cash or personal check. A fee will be assessed on returned checks. Accounts need to stay current in order to maintain ongoing treatment. Unpaid accounts over 30 days old are routinely reviewed for submission to our collection agency.

**APPOINTMENT CANCELLATION POLICY:** In order to provide the best service to clients, clients are asked that cancellations for scheduled appointments be received 24 "business" hours in advance. **Unkept or late cancelled appointments will be charged the full fee for the appointment.**

## **I HAVE READ AND UNDERSTAND THE ABOVE STATED POLICIES**

\_\_\_\_\_

**Responsible Party Signature**

\_\_\_\_\_

**Date**

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## Adult Intake Questionnaire

### Client Information

Name \_\_\_\_\_ First Appointment Date \_\_\_\_\_  
Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Religion \_\_\_\_\_ Marital Status \_\_\_\_\_  
Race \_\_\_\_\_ Children \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_  
With whom are you currently living? \_\_\_\_\_

Who referred you; how did you hear about me? \_\_\_\_\_

What is bringing you in for therapy? How long has this been going on?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Why are you seeking an evaluation at this time? What are your goals in being here?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**PRIOR ATTEMPTS TO CORRECT PROBLEMS/PRIOR PSYCHIATRIC HISTORY**

(Please include contact with other professionals, medications, types of treatment, etc.)

**MEDICAL HISTORY**

Current medical problems/medications: \_\_\_\_\_

Current supplements/vitamins/herbs: \_\_\_\_\_

Past medical problems/medications: \_\_\_\_\_

Other doctors/clinics seen regularly: \_\_\_\_\_

Any history of head trauma, concussion or significant accidents? (describe): \_\_\_\_\_

Ever any seizures or seizure like activity? \_\_\_\_\_

Prior hospitalizations (place, cause, date, outcome): \_\_\_\_\_

Any suicidal ideation: Yes / No

Any suicide attempt in past year: Yes / No

Any past /prior hospitalizations for suicide attempts? Yes / No If Yes, describe \_\_\_\_\_

**CURRENT LIFE STRESSES** (include anything that is currently stressful for you, examples include relationships, job, school, finances, children) \_\_\_\_\_

**Sleep behavior:** sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed) \_\_\_\_\_

**School History:** Last grade completed \_\_\_\_\_ Last school attended \_\_\_\_\_

Average grades received \_\_\_\_\_ Specific learning disabilities \_\_\_\_\_

Learning strengths \_\_\_\_\_

Any behavior problems in school? \_\_\_\_\_

What have teachers said about you? \_\_\_\_\_

**Employment History:** (summarize jobs you've had, list most favorite and least favorite)

Any work-related problems? \_\_\_\_\_

What would your employers or supervisors say about you? \_\_\_\_\_

**Military History?** \_\_\_\_\_

**Ever Any Legal Problems?** \_\_\_\_\_

**Alcohol and Drug History:** (Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel; what benefit you got from them.). These include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you or have you ever experienced withdrawal symptoms from alcohol or drugs? \_\_\_\_\_  
Has anyone told you they thought you had a problem with drugs or alcohol? \_\_\_\_\_  
Have you ever felt guilty about your drug or alcohol use? \_\_\_\_\_  
Have you ever felt annoyed when someone talked to you about your drug or alcohol use? \_\_\_\_\_  
Have you ever used drugs or alcohol first thing in the morning? \_\_\_\_\_  
Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate) \_\_\_\_\_  
Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew) \_\_\_\_\_

**Any history of physical or sexual abuse:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **FAMILY HISTORY**

**Family Structure** (who lives in your current household, please give relationship to each):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Marital or Relationship Satisfaction** \_\_\_\_\_  
\_\_\_\_\_

**Significant Developmental Events** (include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**History of Past Marriages** \_\_\_\_\_  
\_\_\_\_\_

**Natural Mother's History:** age \_\_\_\_\_ occupation \_\_\_\_\_  
School: highest grade completed \_\_\_\_\_ Learning problems \_\_\_\_\_  
Behavior problems \_\_\_\_\_ Marriages \_\_\_\_\_  
Medical Problems \_\_\_\_\_  
\_\_\_\_\_

Childhood atmosphere (family position, abuse, illnesses, etc) \_\_\_\_\_  
\_\_\_\_\_

Has mother ever sought psychiatric treatment? Yes \_\_\_ No \_\_\_ If yes, for what purpose? \_\_\_\_\_  
\_\_\_\_\_

Mother's alcohol/drug use history \_\_\_\_\_  
\_\_\_\_\_

Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations?

(specify) \_\_\_\_\_  
\_\_\_\_\_

**Natural Father's History:** age \_\_\_\_\_ occupation \_\_\_\_\_

School: highest grade completed \_\_\_\_\_ Learning problems \_\_\_\_\_

Behavior problems \_\_\_\_\_ Marriages \_\_\_\_\_

Medical Problems \_\_\_\_\_

Childhood atmosphere (family position, abuse, illnesses, etc) \_\_\_\_\_

Has father ever sought psychiatric treatment? Yes \_\_\_ No \_\_\_ If yes, for what purpose? \_\_\_\_\_

Father's alcohol/drug use history \_\_\_\_\_

Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations?

(specify) \_\_\_\_\_  
\_\_\_\_\_

**Siblings** (names, ages, problems, strengths, relationship to patient) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Children** (names, ages, problems, strengths) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Cultural/Ethnic Background** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Spiritual Background** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Describe your relationships with friends** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Describe yourself** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Describe your strengths** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_