THE ART OF
Relationships
GREG DUDZINSKI, MS, LPC

Adult Intake Questionnaire

Name: _____

D.O.B. _____ Age:_____

Address: _____

_____

Telephone: (____)_____ Email: _____

May I leave a voice message, text, or email? ☐ Yes ☐ Yes, only _____ ☐ No

Relationship Status:

☐ Single ☐ Married ☐ Partnership ☐ Divorced ☐ Separated ☐ Widowed

Reason you are seeking services:

_____

_____

Please tell me your strengths (what you like about yourself):

_____

_____

Family Dynamics

☐ Nuclear ☐ Stepfamily ☐ Multiracial ☐ Foster Care ☐ Adopted

If adopted, is your child aware that s/he is adopted? Yes No

If adopted, at what age was your child/teen when adoption was finalized? _____

Who currently resides in primary home: _____

_____

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Current Legal Residency Status : (please check all items that apply with description of marked items below)

☐ Biological Family ☐ Foster Care ☐ Guardian ☐ Adopted ☐ Adoption Pending

☐ Adoption Disrupted ☐ Court Ward ☐ Kinship Care ☐ Other

Comments: _____

_____

Cultural & Ethnic Affiliation

☐ African American ☐ White ☐ Hispanic ☐ Asian ☐ Biracial ☐ Native American

☐ Arab ☐ Chaldean ☐ Other

Does the client/consumer identify with their heritage and does it impact their self concept? _____

Spirituality / Religious Domains:

☐ Catholic ☐ Jewish ☐ Christian / Protestant ☐ Islamic ☐ Jehovah's Witness

☐ Mormon ☐ Hindu ☐ Agnostic ☐ Atheist ☐ Other _____

Active Participation in above marked? Yes No

Pregnancy or Birth Complications: (please check problem areas and describe below)

☐ Majority of Pregnancy on Bed Rest ☐ Bleeding ☐ High Blood Pressure

☐ Tobacco Use ☐ Alcohol Use ☐ Drugs ☐ Jaundice ☐ Oxygen Loss

☐ Premature Birth / How Many Months? _____ ☐ Breech Birth ☐ Cesarean

Was oxygen give to your infant at birth? _____ ☐ Other _____

Please Describe above marked item(s) _____

_____

Developmental Delays or Challenges: (please check problem areas and describe below)

☐ Age first walked ☐ Age first talked ☐ Speech / Language

☐ Toilet Training ☐ Separation Issues ☐ Fine Motor Skill Usage ☐ Bedwetting

☐ Current Eating Challenges ☐ Other

Description of above marked area(s): _____

_____

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Physical Health Related Issues (please check problem areas and describe below)

☐ Physically or otherwise health impaired ☐ Sleeping Patterns ☐ Allergies

☐ Nutrition ☐ Severe or Rapid Weight Loss ☐ Obesity ☐ Major Illness

☐ Sensory Impairment (Vision, Hearing, or Other) ☐ Major Accidents/Injuries ☐ Diabetes

☐ Seizures ☐ Convulsions ☐ Other _____

Has child had her/his hearing tested? _____ Vision? _____

For Girls: Menstruation started? Yes No Age of First Period: _____

Problems with above? Yes No If yes, please describe _____

Pregnancies? Yes No Terminated Pregnancies: _____

Description of Above Checked: _____

_____

_____

Current Family or Individual Stressors: (please check problem area(s) and describe below)

☐ Home / Family ☐ Relationship ☐ Financial ☐ Legal Issues ☐ Loses

☐ School Related ☐ Multiple Changes ☐ Health ☐ Other

Description of above checked area(s): _____

_____

_____

Known history of abuse or neglect (please check problem area(s) and please describe below at what age is/was event(s), perpetrator, and if event(s) is present or past?)

☐ Physical ☐ Emotional ☐ Verbal ☐ Sexual ☐ Harassment

☐ Domestic Violence ☐ Other _____

Was child a: ☐ Witness ☐ Victim or ☐ Both

Are these events current or past? (please circle one)

Description of above checked areas: _____

_____

_____

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Known Addictive Habits or Substances (please check problem areas and describe below)

☐ Gambling ☐ Eating Patterns ☐ Spending ☐ Shopping ☐ Sexual

☐ Caffeine ☐ Nicotine ☐ OTC ☐ Alcohol ☐ Amphetamines ☐ Cocaine or Crack

☐ Meth ☐ Sedatives ☐ Hallucinogens ☐ Narcotics ☐ Marijuana ☐ Other

Current or Past (Please circle one)

Description of above checked area(s):_____

_____

Self Injurious Behavior: (leave blank if none)

☐ Currently Suicidal ☐ Past suicide attempts ☐ High risk behaviors

☐ Impaired Judgment ☐ Family suicide attempts ☐ Family successful suicides

☐ Other

Description of above checked area(s): _____

_____

Education (Please identify current school, grade, or highest grade completed. If special ed, check type.)

Current Grade: _____

School: _____

School District:_____

☐ Performing well ☐ Certified EI ☐ Certified LD ☐ Speech/Language Impaired

☐ Hearing Impaired ☐ Visual Impairments ☐ Poor Grades ☐ Behavioral Problems

☐ Multiple Suspensions ☐ Multiple Detentions ☐ Expelled ☐ Other _____

Description of checked area(s): _____

_____

Social Skills (Please check problem areas and describe below)

☐ Peer Relationships ☐ Lacks Friends ☐ Leisure Activities ☐ Not linked w/ community

☐ Other _____

Description of above checked areas and **please include current activities your child enjoys**:

_____

_____

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Former Treatment History (Please check appropriate area and describe below)

☐ Prior hospitalizations ☐ Prior substance abuse ☐ Outpatient Counseling

☐ Current Psychiatrist ☐ Attends Support Group ☐ Medications ☐ Other

Description of above checked area and clinic or hospital name and location:

_____

_____

Moods, Behaviors, and Thought Processes Observed (please check all that apply):

☐ Anxious/Fretful	☐ Depressed	☐ Poor Attention
☐ Angry/Irritable	☐ Exaggerates abilities	☐ Animated
☐ Fearful	☐ Obsessive/Compulsive	☐ Preoccupations
☐ Paranoid	☐ Phobias	☐ Hallucinations
☐ Shy	☐ Moody	☐ Bizarre Actions
☐ Worries a lot	☐ Lies often	☐ Steals
☐ Easy Going	☐ Fighting	☐ Sleep walks
☐ Gets Bullied	☐ Generous to others	☐ Set Fires
☐ Bullies Others	☐ Lazy	☐ Hyperactive
☐ Confident	☐ Sloppy Hygiene	☐ Selfish
☐ Loner /Withdrawn	☐ Friendly	☐ Often sick
☐ Sexual acting out	☐ Daydreams frequently	☐ Constant Stomach Aches
☐ Angry	☐ Creative	☐ Frequent headaches
☐ Nightmares often	☐ Difficulty waking up	☐ Binge eating or anorexic
☐ Expects Failure	☐ Well liked	☐ Manipulative

☐ Easily influenced by peers ☐ Other _____

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Physician Information:

Current Physician / Pediatrician: _____
Address: _____
Phone: _____
Last Physical or Visit: _____ Reason for visit: _____

Former Medications, dosage, and reason for taking: _____

_____

Current Medications, dosage and reason for taking. Are they effective?:

_____

_____

Is there any other information that this questionnaire may have missed that you feel is important?
YES NO

If yes above, please describe: _____

_____

Signature: _____ **Date:** _____

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