STUDIO FOR CHANGE

ADULT INITIAL QUESTIONNAIRE

Client Information:

Client Name: _____ Nickname or Preferred Name: _____

Age: _____ Date of Birth: _____ Gender: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Email: _____

Address: _____

Relationship Status: _____ Current Relationship Length: _____

Highest level of education completed: _____ Occupation: _____

Ethnic / Cultural Background: _____

Religious / Spiritual Background: _____

Current Religious / Spiritual Practice: _____

Additional People Living in the Home:

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Payment:

Person responsible for payment: _____

Signature of person responsible for payment: _____

Appointment Reminder:

If you would like an automated appointment reminder one day before each appointment, please provide your cell number if you'd like a text OR your e-mail address if you'd like an e-mail:

Cell phone number: _____ E-mail address: _____

Referred By:

How did you learn about (BUSINESS NAME)? _____

If you found us on the internet, what site were you on? _____

In Case of Emergency, Please Call:

Name: _____ Relationship: _____ Phone #: _____

Presenting Problem:

1. What is the main reason you came to therapy? _____

2. What have you tried so far to address your concern? _____

3. How do you hope I can be of help? _____

4. What do you think is a realistic time frame for solving your problem? _____

Goals and Strengths:

1. What are your goals for therapy? _____

2. What are your strengths? _____

3. What are your interests? _____

4. Describe your current self-care strategies: _____

Client History:

1. Have you ever enlisted or served in the military? If so, when and for how long? _____

2. Please describe any physical or mental health struggles you have experienced in the past including any depression or suicide attempts: _____

_____

_____

3. Have you even been hospitalized for psychiatric care? If so, when and for what? _____

_____

_____

4. Please describe any physical, emotional, or sexual abuse you have experience, including when and by whom: _____

_____

_____

Please check any of the following you have experienced in the past year:

- ☐ Death of a family member or close friend
- ☐ Death of a spouse / partner
- ☐ Discrimination
- ☐ Divorce or separation
- ☐ Emotional, physical, or sexual abuse
- ☐ Family member left home
- ☐ Fired or laid off from a job
- ☐ Legal problems
- ☐ Major injury or illness
- ☐ Marriage / New partnership
- ☐ Moved
- ☐ New family member (through birth, adoption, or marriage)
- ☐ Retired from job
- ☐ Spouse / partner job loss or change
- ☐ Started or finished school
- ☐ Other: _____

_____

Please check any of the following you have experienced in the past month:

- ☐ Angry or hostile
- ☐ Anxious
- ☐ Binging / purging
- ☐ Change in alcohol or drug use
- ☐ Crying frequently
- ☐ Difficulty concentrating
- ☐ Easily distracted
- ☐ Fearful
- ☐ Feeling depressed or sad
- ☐ Feeling lonely
- ☐ Feeling restless or fidgety
- ☐ Financial stress
- ☐ Frequent stomachaches or headaches
- ☐ Hearing voices
- ☐ Hopelessness
- ☐ Irritable
- ☐ Lack of self-confidence
- ☐ Nightmares
- ☐ Panic attacks
- ☐ Restricting food
- ☐ Seeing things that are not there
- ☐ Self-harm
- ☐ Sexual preoccupation
- ☐ Sleeping less
- ☐ Sleeping more
- ☐ Thoughts of killing yourself
- ☐ Trouble sleeping
- ☐ Unusually excited or “up” mood
- ☐ Weight change
- ☐ Withdrawing from friends and family

Substance Use:

Substance	Age at First Use	Date of Last Use	Current Use: Frequency and Amount
Alcohol			
Cocaine			
Ecstasy			
LSD			
PCP			
Mushrooms			
MDMA			
Heroin			
Inhalants (glue, paint, nitrous oxide, Co2)			
Marijuana			
Prescription Pain Medication			
Stimulants (amphetamine, methamphetamines)			
Sedative (ex: Valium, Xanax, barbiturates)			
Tobacco/Nicotine			

Have you ever experienced any alcohol or substance abuse problems? If so, please describe: _____

_____

_____

Health and History:

Physician Name and Number: _____ Date of Last Visit: _____

Psychiatrist Name and Number: _____ Date of Last Visit: _____

1. Starting with birth and proceeding up to the present, list all allergies, diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had: _____

_____

_____

_____

_____

2. Have you ever had any previous psychotherapy? If so, when, with whom, how long, and did you feel it was helpful? _____

Prescribed Medications	Purpose	Dose	Side Effects

Family History:

1. Describe any family history of physical or mental illness including depression or suicide: _____

2. Describe any family history of substance use or abuse: _____

3. Has anyone in your family ever been hospitalized for psychiatric care? If so, who and for what? _____

4. Has anyone in your family ever witnessed or experienced any domestic violence or emotional, physical, or sexual abuse? If so, who, what, for how long, and by whom? _____

5. Is there anything else you would like me to know about you, your relationships, or your family: _____