FOCUS CENTERS, PLLC

Phil Ellis, Ph.D.

Adult Intake Questionnaire

Name: _____ Age: _____Date: _____

Presenting problem and prior treatment

1. What is your major concern that led you to seek help?

_____

_____

_____

_____

_____ _____

2. What other concerns do you have?

_____

_____

_____

_____

_____ _____

3. Is there a particular reason you are seeking an appointment now?

_____

_____

_____

4. Have you ever had a psychological evaluation or had intellectual or achievement testing at school?

No _____ Yes _____ If yes, describe when, with whom and what were the results.

_____

_____

_____

_____

_____ _____

Please turn to the other side

5. Have you ever been in counseling, or have you ever sought help for these problems before?

No _____ Yes _____ If yes, enter the information below.

Date(s) and number of visits of **most recent counseling**:
Who did you see?
Explain what happened and the results:
Date(s) and number of visits of **any earlier counseling**:
Who did you see?
Explain what happened and the results:

6. Have you ever taken medication for attention, behavior or mood problems? No ____ Yes _____

If yes, carefully enter the following information for each medication in the table below.

Medication			
Dose			
Reason prescribed			
Dates Taken			
Prescribing Physician			
Benefits			
Problems			
If discontinued, why?			

7. Have you been to the doctor in the last year? No _____ Yes _____ If yes, were the current concerns discussed and if so, what recommendations were made?

_____

_____

8. How is your health currently? Are you being treated for anything?

_____

_____

9. Are you allergic to anything including medications? No _____ Yes _____ If yes, please describe.

_____

10. What medical or physical problems have you had? Mark an *X* and then describe below.

	Birth to 5	6-12	13-18	19-24	25-50	50+
Allergies or food sensitivities	_____	_____	_____	_____	_____	_____
Ear infections, frequent colds	_____	_____	_____	_____	_____	_____
Poisoning or drug overdose	_____	_____	_____	_____	_____	_____
Serious illnesses or surgeries	_____	_____	_____	_____	_____	_____
Vision or hearing difficulties	_____	_____	_____	_____	_____	_____
Speech disorders	_____	_____	_____	_____	_____	_____
Serious accidents/Injuries	_____	_____	_____	_____	_____	_____
Any blows to the head or concussions	_____	_____	_____	_____	_____	_____
Any loss of consciousness or seizures	_____	_____	_____	_____	_____	_____

_____

_____

_____

11. Do you get headaches? No _____Yes ____ If yes, please describe the type, frequency and severity?

_____

_____

12. List any medications you are <u>currently</u> taking for other health problems in the columns below.

Medication			
Dose			
Purpose			
Date Started			
Physician			
Side Effects			

Please turn to the other side

13. Were there any problems or unusual circumstances during the pregnancy, delivery or first months of your life?

    No _____ Yes _____ Don't know _____ If yes, please describe.

_____

_____

_____

14. Were you adopted? No _____ Yes _____ If yes, at what age? _____

15. Were there any developmental problems including delay in learning to crawl, walk or talk?

    No _____ Yes _____ Don't know _____ If yes, please describe.

_____

_____

_____

16. As an infant, were you told you were difficult, demanding, hard to soothe, colic or had problems sleeping?

    No _____ Yes _____ Don't know _____ If yes, please describe.

_____

_____

_____

17. Were there any disruption or major difficulties that could have affected your bonding with your mother during the first three years?

    No _____ Yes _____ Don't know _____ If yes, please describe.

_____

_____

_____

18. As a child, were your said to have been extremely physically active or always "on the go"?

    No _____ Yes _____ Don't know _____ If yes, please describe.

_____

_____

_____

19. Please describe any of the following you have experienced.

Problem Areas	Age(s)	Nature of event and impact
Problems in your family while your were growing up, such as separation, divorce or remarriage; psychiatric, alcohol or drug problems of parent, death or serious health problems of family member; change in living arrangements		
Problems in your family since being an adult, such as separation, divorce or remarriage; psychiatric, alcohol or drug problems of a spouse or child; death or serious health problems of family member; change in living arrangements		
Emotional, physical or sexual **abuse**; neglect, or exposure to domestic violence or on-going intimidation, harassment, discrimination		

Problems in social network such as death or loss of close friends rejection by peers, or frequent moves causing loss of friends		
Educational problems including learning problems, academic problems, inadequate schooling		
Problems with housing, living arrangements or sudden loss of family income, such as homelessness, frequent moves or suddenly not having family income		
Medical problems, illness or surgeries		
Problems related to the police, or interaction with the legal system, being a victim of a crime or a ward of the court		
Exposure to disaster, accidents or other trauma		

20. How well did you get along with your parents while growing up?

Mother:_____

_____

_____

Father:_____

_____

_____

21. If you are married, how would you evaluate your marriage?

_____

_____

_____

22. How close are you to your parents and siblings now?

_____

_____

_____

23. How strong a network of friends do you have?

_____

_____

_____

_____ _____

24. Are you active in a faith and, if so, how strong a support does it provide?

_____

_____

_____

25. What other sources of personal strength do you call upon to face problems?

_____

_____

_____

_____

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26. What is the furthest grade reached or highest degree attained in school? _____

27. What was the Grade Point Average in your last schooling? _____

28. Please mark with an "X" when any of the following has occurred.

	Elementary School	Middle School	High School	College
Reading difficulties	_____	_____	_____	_____
Math difficulties	_____	_____	_____	_____
Writing difficulties	_____	_____	_____	_____
Poor grades	_____	_____	_____	_____
Homework problems	_____	_____	_____	_____
Behavior problems at school	_____	_____	_____	_____
Peer Problems	_____	_____	_____	_____
Strongly disliked school	_____	_____	_____	_____
Resource or other remedial assistance	_____	_____	_____	_____
Special Education placement	_____	_____	_____	_____
On Individualized Education Plan (IEP)	_____	_____	_____	_____

29. Please circle any of the following that are <u>current</u> problems:

Difficulty learning to read, blend sounds or read smoothly
Problems tracking while reading (losing place, missing words)
Difficulty remembering what was read
Difficulty with math calculations
Difficulty understanding math concepts
Difficulty at written composition
Difficulty spelling
Poor handwriting (even if writing slowly)
Difficulty drawing or copying figures
Poor sense of direction
Poor balance or coordination

Please describe your greatest strengths and any special abilities or talents.

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_____

_____

30. Have you ever had problems keeping jobs, getting along with supervisors or coworkers, or changing jobs frequently?

_____

_____

_____

Attention problems

31. What problems, if any do you have with daydreaming, staying on-task or being disorganized? At what age did you first notice this? Do the problems occur mainly at home, at school or work or in all places?

_____

_____

_____

32. What problems, if any, do you have with hyperactivity, stimulus seeking or feeling restless? At what age did you first notice this? Do the problems occur mainly at home, at school or work or in all places?

_____

_____

_____

33. What problems, if any, do you have with impulsivity, impatience or acting without thinking of consequences? At what age did you first notice this? Do the problems occur mainly at home, at school or work or in all places?

_____

_____

_____

Oppositionality, anger and conduct problems

34. What problems do you have with being asked to do small tasks or requests? Are you easily irritated by such requests, are you likely to remember the request and actually complete the request if you start it? How much do you feel that any problems in this area come from not liking to be told to do things versus being distractible or disorganized?

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_____

35. What problems, if any, do you have with irritability and anger? When angry, are you more likely to let the anger go quickly or hold onto resentment?

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Please turn to the other side

36. Do you ever become violent or destructive? Have you ever hurt anyone intentionally or threatened to kill someone? Have you ever been cruel to animals? What interest do you have in weapons?

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37. What problems, if any, do you have with getting into trouble, unlawful activity or delinquent actions that could cause legal consequences?

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38. In relating to others, what problems, if any, do you have in terms of lacking empathy, being manipulative or failing to show remorse when appropriate?

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_____ _____

Depression

39. What problems do you have with your feelings being too easily hurt? Are there any signs of problems with self-esteem? Are there particular things about yourself you feel especially bad about?

_____

_____

_____

40. What problems, if any, do you have with sadness, moodiness, withdrawing from friends or activities, appearing down, lacking motivation or enthusiasm, changes in eating pattern, loss of sex drive, crying easily or other signs of depression?

_____

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_____

_____ _____

41. Have you ever talked about wishing you were dead or discussed or attempted suicide?

_____

_____

42. What problems, if any, do you have with fears, tension, anxiety, panic attacks, phobias, being very uncomfortable in new situations or extreme shyness? How has that changed over time?

_____

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_____ _____

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43. In what ways do stress or anxiety cause you physical symptoms such as back or neck aches, headaches, intestinal problems or dizziness? How has that changed over time?

_____

_____

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_____ _____

44. Has anything ever happened to you that when recalled causes you extreme distress? Are there any such events that continue to cause bad dreams? No _____Yes _____ if yes, please describe

_____

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_____ _____

45. Are there any ideas, fears or concerns about which you obsess or worry?

_____

_____

_____

46. Do you have any habits, rituals or other compulsive behaviors?

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_____

47. What problems do you have with muscle or verbal tics? These are repetitive movements or noises such as eye blinking, facial twitching, or noises such as grunting, snorting, squeaking, or humming.

_____

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_____

Substance use

48. Do you smoke? Yes _____ No _____ If so, how much? _____

49. Do you drink coffee? How much other caffeinated beverages do you drink?

_____

_____

50. Do you drink alcohol? If so, describe how much and under what circumstances. Has anyone, including yourself, expressed concern about your drinking? Have you ever sought help to control or stop drinking? Was this ever a problem when you were younger? If you don't drink, what effect did it have if you ever tried it?

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_____

51. Do you use any drugs? If so, describe how much and under what circumstances. Has anyone, including yourself, expressed concern about your use? Have you ever sought help to control or stop using? Was this ever a problem when you were younger? Did you ever try any drug that you did not like the effect?

_____

_____

_____

_____

Other health related behaviors

52. How healthy is your diet? What problems, if any, have you had with sugar cravings, dieting or maintaining weight? Have you ever been tried on any special diets?

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_____

53. How much activity or physical exercise do you get?

_____

_____

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_____ _____

54. (Females only) what problems, do you have with unusual depression, irritability or discomfort during the week or so before the menstrual period?

_____

_____

_____

55. Please circle any of the following sleep problems you experience and then describe the severity or frequency in the space below:

Difficulty waking in morning	Frequent waking during night	Snoring
Difficulty falling asleep	Nightmares (bad dreams)	Bedwetting
Not rested after sleep	Sleeping too much	Delays going to bed
Physically restless sleep	Teeth grinding	Sleep Apnea

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_____ _____

56. Anything else it would be helpful to know about?

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_____ _____

57. For each of the following, please identify <u>any relatives</u> (children, siblings, parents, grandparents, aunts or uncles) who <u>may</u> have had problems in these areas (i.e. "One of Mom's sisters took medication for depression.", "One of Dad's brother drank heavily from age 15 to 40 and then went into treatment").

Check here if father's family history is unknown. ( ) Check here if mother's family history is unknown. ( )

Problems with attention including being distractible, hyperactive or impulsive.

Problems in school or problems learning to read,

write or do math.

Problems with opposionality,

anger, violence or criminal behavior

Depression or Anxiety

Headaches/migraines/

seizures/neurological problems

Alcohol Problems

Drug abuse

Serious health problems

Other mental or emotional illness

Thank you for completing this form!