Heather Carroll, PsyD, PLLC

2121 South Oneida St. Suite 540 - Denver, CO 80224

www.carrolltherapyconnections.com – phone: 303-756-1355

ADULT INTAKE QUESTIONAIRRE

Client Information

Name: _____

Date of Birth: _____ Age: _____

Guardian Name (If applicable) _____
_____

Are parents married? _____ If not, please describe current custody and mental health/medical decision making arrangements:_____
_____

Address: _____

_____

Relevant Phone #'s: _____
(Include cell numbers, work numbers, or wherever is easiest to reach you)

Describe any confidentiality considerations you would like me to take when using the above contact numbers: _____
_____

Referred by: _____

I often thank referrals for sending you my way. Is this okay with you? _____
(This only applies to other providers- not friends or past clients)

Emergency Contacts

Name of one or more emergency contacts and relationship(s) to you:
_____

Phone #'s: _____

Current Concerns

Please describe the primary concerns or goals for therapy for you or your family

Concern/goal #1

Concern/goal #2

Concern/goal #3

What steps have you taken to address these concerns in the past? What has worked? What has not worked?
_____
_____
_____

What prompted you to seek services now? _____
_____

How would you describe an ideal therapist? _____
_____

Do you have ideas about an approach or techniques that work best for you? _____
_____
_____

What suggestions would you give your therapist in working with you? _____
_____
_____
_____

The purpose of the following questions is to gain historical information about you that will assist me in providing you with the most comprehensive service. Please do your best to answer the questions as thoroughly as possible.

Physical Health

Please list any major physical illnesses, accidents, and surgeries in your history along with dates and ages.
List all major or chronic illnesses with dates and ages:
_____
_____
_____

Still experiencing symptoms? Yes/No? If so, please describe symptoms:_____
_____

Any lasting effects? _____
_____

Please describe any major accidents or falls along with dates and ages: _____

_____

Did any result in a head injury or concussion? _____

Any changes in behavior or cognitions following the injury? _____

_____

If so please describe changes and duration. _____

_____

Please describe any major surgeries along with dates and ages: _____

_____

Any lasting problems or pain? _____

Are you currently experiencing any chronic pain? If so, please describe the pain, intensity, duration, and cause.

_____

_____

_____

Please provide information regarding any current or past medications that you have taken for an extended period of time. It is especially important to include all medications that are related to your current concerns.

Medication	Dates taken	Dosage	Purpose	Effective?

Name of current prescribing physician or psychiatrist: _____

How many hours of sleep do you or per night? _____

Describe any difficulties with sleep: _____

_____

How would you describe your eating habits? _____

_____

Any recent weight gains/losses not related to growth? _____

How do you feel about your current weight? _____

_____

How do you feel about your physical health condition? _____

_____

Are there any concerns with your vision or hearing? If so, describe: _____

_____

Do you have any difficulties with motor skills or coordination? If so describe: _____

_____

Do you have any sensory sensitivity? Is there excessive avoidance of some sensory stimulation or any excessive sensory seeking behaviors? If so, describe: _____

_____

Social

How would you describe your friendships, including the quantity and quality of these relationships?
_____
_____

Do you have difficulty making or keeping friends? If so, describe these difficulties. _____
_____

How do you spend social time? What kinds of activities do you enjoy? What do you do for fun (e.g. hobbies, interests)? _____
_____
_____

What is your current relationship status? (Circle one)

Partnered/Married	Single	Widowed
Significant Other	Divorced	Remarried

How long have you been in your current relationship? _____

How would you describe your relationship? _____
_____
_____

Name and occupation of your partner:_____

How would you describe your partner? _____
_____

Do you have any children? If so, what are their names and ages? How would you describe them? _____
_____
_____

How would you describe your sexual orientation? How would you describe your gender identity?
_____

Psychological

Have you ever been diagnosed with a mental health disorder? If so, please describe and discuss any current symptoms._____
_____

Have you ever had psychological testing? If so, describe results and include who conducted the testing.
_____
_____

Has anyone in your family ever been diagnosed with a mental health disorder? Indicate family member/diagnosis.
_____
_____
_____

Describe any past therapy experiences (include dates). What worked or didn't work? _____
_____

Have you ever been psychiatrically hospitalized? Yes/No (If, "yes," where and when?): _____
_____

Please describe your typical mood: _____

Please describe your personal strengths: _____
_____

Please circle any of the following that you/ your child experienced in the last 6 months:

Increased/decreased appetite	Feeling paranoid	Trouble concentrating
Lack of energy/lethargy	Racing thoughts	Increased anger
Isolating from others	Increased irritability	Sexual issues
Repetitive behavior	Mood swings	Abuse of alcohol/drugs
Loss of Interest	Nervousness	Memory problems
Relationship issues	Violent actions	Procrastination
Feeling empty	Panic attacks	Confusion
Recurring thoughts	Change in weight	Hearing voices others don't
Hopelessness	Easily frustrated	Seeing things others don't
Extreme worry	Feeling stressed	Disorientation
Crying spells	Low self-esteem	
Nightmares	Depressed mood	
Increased fears	Anxiety	
Flashbacks	Unusual/extreme euphoria	
Sleep problems	Increased fatigue	
Too much energy	Recklessness	
Short attention span	Self-hate	

Do you feel that you have difficulties using coping skills? _____

Please describe things that you do to cope with stressors? _____
_____

Have you ever engaged in self-harm such as cutting, head banging, or any other purposeful injury to self?
_____

Do you feel that you have a difficult time controlling your anger? _____

Have you ever become violent with another person? If so, when and what situation? _____
_____

Have you ever spent time in jail, prison, or detention? If so, when and for what crime? _____
_____

Have you had any suicidal thoughts or attempted suicide in the last six months? _____
_____

Have you ever attempted suicide? _____

Education and Occupation

What is the last grade of school that you completed? _____

How would you describe your experience in school? _____

Is there a history of learning problems? If so, describe: _____
_____

Please describe family values towards school and education: _____
_____

Has anyone in your family been diagnosed with a learning disability or other disability that affects learning?
_____

Did you serve in the military? If so, when and where were you stationed? What was your job?
_____

What kind of work are you doing now? _____

Do you enjoy your job? Why or why not? _____

Describe your ideal job: _____

Environmental

Describe any environmental trauma you may have experienced
(e.g., tornados, floods, hurricanes, etc.): _____
_____

Describe any sexual/physical/mental abuse: _____
_____
_____

Have you ever been the victim of a violent crime? If so, please describe: _____
_____
_____

Please describe any significant environmental stressors that have affected you: _____
_____
_____

Family and Cultural Information

Please list all family member's living in your/home and the relationship to you.

Name	Gender	Age	Relationship

Please provide information regarding your parents.

Father:
Living or deceased? _____
If deceased, how old were you when he died? _____
Cause of death: _____

Mother:
Living or deceased? _____
If deceased, how old were you when she died? _____
Cause of death: _____

Who would you say was your/your child's primary caretaker? _____

Are there siblings? _____

If so, how would you describe the relationship between your children? _____
_____
_____

How would you describe your family's religious values? Do you have similar values? If not, please describe:
_____
_____

Describe any past family Dept. of Human Services involvement: _____
_____

Describe any current family Dept. of Human Services involvement:_____
_____

Does your family currently have a caseworker? _____
_____

I know that I have asked you a lot of questions, but is there any additional information that you feel would be important to add? _____
_____
_____

Please sign below to indicate that the above information is accurate to the best of your knowledge.

Client Signature _____ Date_____