Kerry J DeVries Inc

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Adult Intake Questionnaire

Please fill out the following intake form to the best of your ability. This will help us better understand and work with you. We realize there is a lot of information and you may not remember or have access to all of it, but do the best you can. This information will be treated with the strictest of confidence as a part of your record at this office. Thank you!

CLIENT IDENTIFICATION **Today's Date:** ___________________________

Name _________________________________ Sex: ☐ Male ☐ Female Age: ____ Birth Date ______________________

Spouse ______________________________________ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home Address: ____

City ____ State ___________ Zip __________________________

Home Phone # _____________________________________ Work # ____

Cell Phone # ____ Email ____

Children's Names & Ages ____

REFERRAL SOURCE

How did you hear about us? ____

MAIN PURPOSE FOR SEEKING SERVICES **(Please give a brief summary of the main problems):**

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PRIOR ATTEMPTS TO CORRECT PROBLEMS:

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

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What was helpful in these past interventions and what was not helpful?

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MEDICAL HISTORY

Current & past medical problems/medications: ______________________________

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____

CURRENT STRESSES (please list current factors that are a source of stress for you, for the family as a unit, for other members of the family- they can be major life stressors or seemingly minor stressors.)

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FAMILY HISTORY

Family Structure (List who lives in the current household and the quality of the relationships with each other):

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____

Current Marital Situation, Nature of the Relationship, and Family Atmosphere:

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Family Development (include marriages, separations, divorces, deaths, traumatic events, losses, etc.):

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____

____

RELIGION:

What is your religious/denominational background?______________________________

Is religion/spirituality an important part of you or your family's life? If yes, please explain how:

____

____

INTERPERSONAL RELATIONSHIPS Describe how you would characterize your relationships with:

Co-Workers ______________________________

Members of the same sex ______________________________

Members of the opposite sex ______________________________

People in authority ______________________________

SELF-CARE Describe how well you take care of yourself physically (eating habits, exercise, sleep, physician visits):

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____

Is there anything else that would be helpful in understanding you?

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Please check any of the following that applied to you during your childhood (check all that apply)

❑ Excessive sleeping/Sleep Difficulties	❑ School/academic problems
❑ Excessive Nightmares	❑ Learning disability
❑ Sexual problems	❑ Attention Deficit-Hyperactivity Disorder
❑ Alcohol/substance abuse	❑ Emotional problems (Depression/anxiety/fears)
❑ Medical/health problems	❑ Bedwetting/toilet training problem
❑ Social/peer problems	❑ Sexual abuse/Physical abuse
❑ Trouble with the law	❑ Behavioral problems
❑ Family member with alcohol/drugs use problem	❑ Significant trauma or loss experienced

Please check each of the following that apply to you:

❑ Pleasant sexual images	❑ Unpleasant sexual images	❑ Depressed mood
❑ Unpleasant childhood images	❑ Lonely images	❑ Excessive fears/Panic attacks
❑ Helpless images	❑ Seduction images	❑ Work or career difficulties
❑ Aggressive images	❑ Images of being loved	❑ Sexual molestation or harassment

Please check any of the following words that you might use to describe yourself:

❑ Intelligent	❑ Horrible thoughts	❑ Unlovable	❑ Worthless
❑ Ambitious	❑ Memory problems	❑ Ugly	❑ Co-dependent
❑ Trustworthy	❑ Suicidal ideas	❑ Honest	❑ Inadequate
❑ Useless	❑ Hard working	❑ Conflicted	❑ Stupid
❑ Morally degenerate	❑ Confident	❑ Attractive	❑ Incompetent
❑ Unattractive	❑ Sensitive	❑ Persevering	❑ Good sense of humor
❑ Confused	❑ Full of regrets	❑ Worthwhile	❑ Concentration problems
❑ Naïve	❑ Considerate	❑ Loyal	❑ Can't make decisions

Please check any of the following that apply to you and circle the frequency:

❑ Marijuana	Never-Rarely-Frequently-Often	❑ Premenstrual upset	Never-Rarely-Frequently-Often
❑ Sedatives	Never-Rarely-Frequently-Often	❑ Menopausal distress	Never-Rarely-Frequently-Often
❑ Painkillers	Never-Rarely-Frequently-Often	❑ Stimulants	Never-Rarely-Frequently-Often
❑ Aspirin	Never-Rarely-Frequently-Often	❑ Bowel disturbances	Never-Rarely-Frequently-Often
❑ Coffee	Never-Rarely-Frequently-Often	❑ Allergies	Never-Rarely-Frequently-Often
❑ Nausea	Never-Rarely-Frequently-Often	❑ Sexual problems	Never-Rarely-Frequently-Often
❑ Alcohol	Never-Rarely-Frequently-Often	❑ Headaches	Never-Rarely-Frequently-Often
❑ Cigarettes	Never-Rarely-Frequently-Often	❑ Sleep problems	Never-Rarely-Frequently-Often

Please check any of the following life events that have occurred for you in the past year:

❑ Death of a spouse	❑ Got married	❑ Change in financial status	❑ Self or spouse stop work
❑ Divorce	❑ Fired at work	❑ Significant achievement	❑ Increase marital conflict
❑ Marital separation	❑ Marital reconciliation	❑ Foreclosure on loan	❑ Changed living condition
❑ Jail term	❑ Retirement	❑ Child left home	❑ Changed work hours
❑ Death of family member	❑ Pregnancy	❑ Trouble with in-laws	❑ Changed residence
	❑ Sexual difficulties	❑ Begin or end school	❑ Changed sleeping habits
❑ Personal injury/ill	❑ Gain family member	❑ Trouble with boss	❑ Change in social activities
❑ Close friend died	❑ Change in line of work	❑ Change in church activities	❑ Change in eating habits