Clifford A. Johannsen, Ph.D.
Licensed Psychologist

ADULT INTAKE QUESTIONNAIRE

Name: _____Today's Date: _____

☐ I live alone ☐ Others living in the home:

Name: Age: Relationship:	Name: Age: Relationship:	Name: Age: Relationship:	Name: Age: Relationship:

What is your educational experience, grades / years completed or degrees earned _____

If you have been working, what is the nature of your work? _____

PRESENTING PROBLEM

Describe the problem(s) that brought you here today:

Check any of the problems that you are having:			
Depression		Feeling hopeless	
Extreme sadness		Crying too much	
Trouble concentrating		Difficulty with sleep	
Memory problems		Lack of energy	

This space reserved for Dr. Johannsen:

Patient's Name: _____ **ADULT INTAKE QUESTIONNAIRE**

Change in eating habits		Weight changes	
Feeling of extreme happiness		Change of sexual interest, function	
Trouble performing your job		Problems getting along with people	
Don't enjoy usual activities		Feeling stressed	
Self-esteem problems		Easily irritated	
Perfectionism		Feeling guilty	
Obsessions or compulsions		Feeling nervous	
Feeling fearful		Sudden feelings of panic	
Physical complaints of pain		Muscle tension	
Problems with anger		Acting violently	
Thoughts of hurting yourself or others		Thoughts of killing yourself or others	

HAVE YOU BEEN IN COUNSELING OR THERAPY BEFORE? **Yes** ☐ **No** ☐

If yes, please describe it below. Start with the most recent time first.

Most recent time?	Approximate Date(s):
Who did you see?	Name:
Explain what happened:	

Time before that?	Approximate Date(s):
Who did you see?	Name:
Explain what happened:	

PREFERENCES. Counseling or therapy is improved when it gets personalized to you. Since you are the expert on yourself, this is a first opportunity to let me know what you like and don't like.

What is your ideal therapist like?
What do you most dread a therapist might do with you?
What have been the most helpful things your past therapists have done?
Do you like homework or reading assignments?
Do you prefer a therapist who mostly listens, or one who talks in a conversational style?
Do you have any other strong preferences for your therapy?

Patient's Name: _____ **ADULT INTAKE QUESTIONNAIRE**

MEDICAL INFORMATION

Have you seen a physician within the last year?	Yes □	No □
If yes, for what problems?		
Who is your primary care physician?	Phone:	
Are you taking any medications, prescription or over-the-counter?	Yes ☐	No ☐
What medications? / How much? / How often? / What reason?		
1.		
2.		
3.		
Do you have allergies to anything?	Yes ☐	No ☐
If yes, please describe the problems:		

Patient's Name: _____ ADULT INTAKE QUESTIONNAIRE

SUBSTANCE USE HISTORY

Do you use/ have you used tobacco (any form)?	Current ☐	Past ☐	No ☐
Do you use/ have you used alcohol?	Current ☐	Past ☐	No ☐
Do you use/ have you used caffeine (any form, including cola drinks)?	Current ☐	Past ☐	No ☐
Do you use/ have you used other mind-altering substances (drugs)?	Current ☐	Past ☐	No ☐

OTHER INFORMATION YOU WOULD LIKE ME TO KNOW ABOUT YOU: