CLIENT QUESTIONAIRRE

Adult intake form

HELEN MUSCOLO, MFT
3184 Old Tunnel Road, Suite D • Lafayette, Calif. 94549

Name: _____

Address: _____ City: _____ ZIP: _____

Email: _____ Phone: _____

Best times to reach you by phone: _____

What is your reason(s) for seeking help at this time? _____

_____

_____

_____

How long have you felt this way? _____

Have you felt this way at another time in your life? _____

_____

What have you tried to help with the above problem(s)? _____

_____

_____

Demographic Information

Age: _____ Occupation: _____ Employer: _____

How long have you lived in this area? _____

What is the last grade of school you completed? _____

Are you: ☐ Married ☐ Partnered ☐ Single ☐ Divorced ☐ Widowed

Current living arrangement? If not living alone, please list who you are living with: _____

_____

_____

Who can you count on for social support? (spouse, mother, father, friend, sibling, etc.) _____

_____

Ethnicity? _____ Religion? _____

Have you done military service? No Yes If yes, what branch? _____

Do you have any serious medical problems? If yes, please list them: _____

_____

_____

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Do you have any memory problems? If yes, please explain: _____

_____

_____

Have you ever had a head injury? If yes, please explain: _____

_____

_____

Do you have any current legal problems? If yes, please explain: _____

_____

_____

How much have the following problems bothered you in the past week? Please circle your answer.

	Not at all	A little bit	Somewhat	Very much	Extremely
Fear of embarrassment causes me to avoid doing things or speaking to people.	0	1	2	3	4
I avoid activities where I am the center of attention.	0	1	2	3	4
Being embarrassed or looking stupid are my worst fears.	0	1	2	3	4
It scares me when I feel shaky.	0	1	2	3	4
It scares me when I feel faint.	0	1	2	3	4
It scares me when my heart beats rapidly.	0	1	2	3	4
It scares me when I become short of breath.	0	1	2	3	4
I avoid (or feel distress in) situations where I fear getting trapped or that I may experience panic.	0	1	2	3	4
I have phobias (excessive or unreasonable fears of specific situations or objects). Describe your specific phobia:	0	1	2	3	4

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that in the past month you had any of the following problems:

I have had nightmares or thought about the event when I did not want to.	0	1	2	3	4
I tried hard not to think about it or went out of my way to avoid situations that reminded me of the event.	0	1	2	3	4
I have been constantly on guard, watchful, or easily startled.	0	1	2	3	4
I have felt numb or detached from others, activities, or my surroundings.	0	1	2	3	4

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Please rate how much you agree with each item by circling your answer.	Not at all	A little bit	Somewhat	Very much	Extremely
Rate any: I am bothered by ideas, images, or impulses that seem silly, weird, nasty, or horrible and I have trouble getting rid of them; or I fear doing something impulsively that might cause embarrassment or harm.	0	1	2	3	4
I check things too much (e.g., locks, switches, the stove) or do calculations repeatedly.	0	1	2	3	4
Rate any: I need to do things in a ritualized way or have things exactly symmetrical or repeat actions until it feels "just right."	0	1	2	3	4
I engage in behaviors that harm my body (e.g., cutting, hitting or scratching self).	0	1	2	3	4
I have intense feelings of anger that I have difficulty controlling.	0	1	2	3	4
I react impulsively in ways that are either self damaging or damaging of my relationships.	0	1	2	3	4
I have headaches.	0	1	2	3	4
I have stomach problems.	0	1	2	3	4
I have muscle or joint pains.	0	1	2	3	4
I have had periods of time with excessive energy, little or no sleep, and have not felt tired.	0	1	2	3	4
I have had periods of time with euphoria or irritability where my thoughts raced and I could not slow my thinking down.	0	1	2	3	4
I have had trouble with grandiose plans, spending sprees, sexual acting out, or other impulsive behavior.	0	1	2	3	4
I have been impaired much of my life by difficulty finishing projects that I have started.	0	1	2	3	4
I have been impaired much of my life by a lack of organization.	0	1	2	3	4
I have been impaired much of my life by problems focusing on tasks.	0	1	2	3	4
I have been impaired much of my life by poor time management.	0	1	2	3	4
I engage in compulsive/binge eating (i.e., eating more than twice what others might eat in a single sitting).	0	1	2	3	4
I purge, use laxatives, or do extreme exercise to control my weight.	0	1	2	3	4
I have a history of not eating with excessive weight loss.	0	1	2	3	4
I have thoughts of suicide.	0	1	2	3	4
I have a specific plan to commit suicide.	0	1	2	3	4

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Please rate how much you agree with each item by circling your answer.

	Not at all	A little bit	Somewhat	Very much	Extremely
In your current relationship, has there been any hitting, insulting, threatening to harm, or screaming?	0	1	2	3	4
I do not feel safe in my own home.	0	1	2	3	4

I have access to guns: ☐ Yes ☐ No (please check one)

I have attempted suicide in the past: ☐ Yes ☐ No (please check one)

I have thoughts of harming others: ☐ Yes ☐ No (please check one)

Past Psychiatric History

Have you ever taken any psychiatric medications? ☐ Yes ☐ No

If yes, please list type, dosage, and dates, if known: _____

Have you ever been to therapy/counseling? ☐ Yes ☐ No

If yes, please list provider(s) and dates, if known: _____

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

If yes, please list location(s) and dates: _____

Have you ever experienced: ☐ Physical abuse ☐ Sexual abuse ☐ Emotional abuse

Substance Use History

In the last 12 months, have you abused alcohol or drugs? ☐ Yes ☐ No

Do you have a drug or alcohol problem? ☐ Yes ☐ No

Do you use drugs (including marijuana)? ☐ Yes ☐ No

If yes, what drugs? _____

Have you ever tried cutting down on your drinking/drug use? ☐ Yes ☐ No

Have you ever felt angry/annoyed when asked about your drinking/drug use? ☐ Yes ☐ No

Have you ever felt guilty about your drinking/drug use? ☐ Yes ☐ No

Have you ever been arrested for a DUI? ☐ Yes ☐ No

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Family Data

Name	Check if living with you	Age, if living	How would you describe this relationship?	Does this person have a history of mental illness or drug/alcohol problems? Please describe.
Spouse/Partner	☐			
	☐			
Children	☐			
	☐			
	☐			
	☐			
	☐			
	☐			
Father/Stepfather	☐			
	☐			
	☐			
Mother/Stepmother	☐			
	☐			
	☐			
Siblings	☐			
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			
Other	☐			
	☐			
	☐			
	☐			
	☐			