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ADULT QUESTIONNAIRE

TODAY'S DATE: _____

NAME: _____ AGE: _____ GENDER: _____ DATE OF BIRTH: _____

ADDRESS: _____ APT #: _____ CITY: _____ ZIP: _____

HOME PHONE: _____ CELL: _____ WORK: _____

Ok to leave a message? Y__ N__

Ok to leave a message? Y__ N__

Ok to leave a message? Y__ N__

EMPLOYER: _____ YOUR JOB: _____

PRIMARY INSURANCE: _____ PLAN NAME: _____

Individual ID #: _____ Group #: _____

IF YOU ARE NOT THE PRIMARY INSURED, WHO IS? _____ DATE OF BIRTH: _____

ID#: _____

____ SINGLE ____ MARRIED; HOW LONG? _____ ____ COUPLED, NOT MARRIED;

____ SEPARATED ____ DIVORCED; HOWLONG? _____ HOW LONG? _____

____ WIDOWED ____ PREVIOUS MARRIAGES; HOW MANY? _____

SPOUSE OR PARTNER: _____ AGE: _____ BIRTHDATE: _____

ADDRESS: _____ APT #: _____ CITY: _____ ZIP: _____

HOME PHONE: _____ CELL: _____ WORK: _____

EMPLOYER: _____

EMERGENCY CONTACT: _____ NUMBER: _____

CHILDREN:

NAME: _____ BIRTHDATE: _____ AGE: _____ M / F

NAME: _____ BIRTHDATE: _____ AGE: _____ M / F

NAME: _____ BIRTHDATE: _____ AGE: _____ M / F

NAME: _____ BIRTHDATE: _____ AGE: _____ M / F

RESPONSIBLE PARTY, IF OTHER THAN YOURSELF: _____**RELATIONSHIP TO CLIENT:** _____**PLEASE DESCRIBE ANY PRIOR THERAPY YOU HAVE RECEIVED; INCLUDE DATES, NAME (S) OF THERAPIST AND NATURE OF PROBLEM:****PLEASE DESCRIBE THE PRESENT PROBLEM:****WHAT DO YOU HOPE TO ACCOMPLISH THROUGH THERAPY?****PLEASE DESCRIBE ANY HEALTH PROBLEMS:****DO YOU SMOKE?** ____ NO ____ YES; HOW MUCH? _____**ALCOHOL USE?** ____ NO ____ YES; HOW MUCH? _____**DO YOU USE ANY OTHER SUBSTANCES?** ____ NO ____ YES; WHAT KIND/HOW MUCH/HOW OFTEN?

ARE YOU TAKING ANY MEDICATION: ____ NO ____ YES; DESCRIBE _____

DO YOU HAVE ANY TROUBLE SLEEPING? ____ NO ____ YES: DESCRIBE _____

RECENT WEIGHT GAIN/LOSS? ____ NO ____ YES; HOW MUCH OVER HOW LONG?

Current Medications	Dose Amount	When do you take it?	How long have you been taking it?	Prescribed for what condition?

ARE YOU CURRENTLY BEING TREATED FOR ANY PHYSICAL OR PSYCHOLOGICAL ILLNESS?

____ NO ____ YES; DESCRIBE _____

NAME OF PHYSICIAN _____

REFERRED FOR SERVICES BY: _____

ANY LABOR & INDUSTRY CLAIMS? ____ CURRENT/PENDING/PAST? _____

CONDITION/INJURY: _____

HAVE YOU APPLIED FOR DISABILITY OR SOCIAL SECURITY? ____ CURRENT/PENDING/PAST?

CONDITION/INJURY: _____

IS THERE ANYTHING ELSE YOU THINK I SHOULD KNOW AS WE BEGIN?