**Karen Corona, LCSW** (OR # L5719 )

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**Adult Intake Questionnaire**

                                            Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    DOB/Age:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Okay to leave message   Yes  or  No

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Okay to leave message   Yes  or  No

Work Phone:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Okay to leave message   Yes  or  No

Emergency Contact Information – Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status:       Single         Married       Divorced/Separated        Partnered       Widowed

Please include dates of any divorce(s), remarriage(s), or spouse’s death

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Names/Ages of Children or Stepchildren: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list who currently lives in your household:   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Occupation/Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Highest Level of Education:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever seen a counselor/therapist or mental health professional in the past?   Yes   /   No

If so, what was the reason for seeking services at that time?

Was it helpful?  Why or why not?

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Are you currently taking any **medications** or supplements?  Yes  /   No

If yes, please list medications (type, dosages, and reason prescribed) Who prescribes your medication?

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Do you have any **health problems**?  If so, please describe:

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Do you **drink alcohol**?  Yes  /   No          If so, how often & how much?

Have you ever tried to cut down or control your drinking/drug use?    Yes  /  No

Are you struggling with a drug or alcohol problem?  Yes  /  No           DUI’s   Yes  /  No

Do you use **illegal drugs**?  Yes  /   No        Past drug use?   Yes  /  No

Have you ever sought treatment for a **substance abuse problem**?   Yes  /   No

If so, what **treatment program** (Rehab facility) did you attend?

Ever attend AA or NA ?  Yes  /  No

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Other **Addiction problems** (past or current):  Circle any that apply to you.

Pill Addiction     Food Addiction     Sexual Addiction     Sex/Love Addicts     Gambling

**Eating Disorder** (Bulimia, Anorexia, or Binge-eating):  Yes  /  No

Have you ever been **hospitalized for psychiatric reasons**?  Yes /  No

If yes, please state reason and date of hospitalization:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever thought about hurting yourself/suicidal ideation?  Yes  /  No

Past history of **suicide attempt**(s)?   Yes  /  No

If yes, method of attempt and date?   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History of the following in childhood**?  Circle any that you have experienced.

Sexual Abuse     Physical Abuse     Emotional Abuse/Neglect     Traumatic experience(s)

**Traumatic Events/Losses**:

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Physical Violence in an Adult Relationship:  Yes  /  No

(**Domestic Violence or Emotional Abuse**)

Reason for seeking counseling at this time?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What are your goals for therapy?   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Client Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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