Name of Client: ______________________________

ADULT QUESTIONNAIRE

The information you provide will help in the planning of your counseling and assist you and your therapist to clarify your therapy goals.

Academic Background

1. Where did you attend high school? ____
2. Did you attend college/professional school? When, where, degree earned? ______________________________________
____
3. Any plans to further your education? __________ If so, when and what? ______________________________________
____

Cultural Background

1. What is your **ethic identity**?
 ___African/African American ___Asian American/ Chinese/ Filipino/ Japanese/ Korean/ Vietnamese
 ___East Indian/Pakistani ___Latino/ Hispanic/ Mexican-American/ Puerto Rican
 ___Middle Eastern ___Native American/ Alaskan Native ___Polynesian/Micronesian
 ___White/Caucasian ___Other (specify) ____
2. How much do you identify with your **ethnic heritage**? (Check one):
 ___Not at all ___A little ___Somewhat ___Moderately ___Strongly
3. **Religious/Spiritual preference:** ____
 Do you consider yourself a religious person? ___Yes ___No or spiritual person? ___Yes ___No
 Comment: ____
 Faith: Group/Denomination in which you were raised: _______________
 Current Congregation: ____________________________
 How active are you? _____Inactive ____ Slightly _____ Moderate ____Very
4. Does your family **speak a language** other than English at home? (Check one):
 ___Not at all ___Very little ___Sometimes ___Frequently ___Always
 If "Sometimes" to "Always", what language is spoken? ____
5. Were you and both your biological parents **born in the USA**? ___Yes ___No ___Unsure
 If no, who was foreign-born, where and what was the approximate age of immigration to the USA? (e.g. myself, Korea, 12; father Korea, 40;etc.) ____
 ____
 ____

Problem Analysis

1. Have you **seen another therapist** in the past twelve months? ___Yes ___No
 If yes, who did you see? ____
2. Have you **ever been hospitalized** for psychological/emotional difficulties? ___Yes ___No
 If yes, explain difficulty, dates hospitalized & type of medication ____
____

PROBLEM DESCRIPTION: Briefly **describe the problem** you most wish help with right now: ___________________________________

____

____

____

3. PROBLEM INTENSITY: How would you **rate the intensity** of the problem or concern that brought you in? (Circle the appropriate number):

1	2	3	4	5	6
Not intense			Moderately Intense		Extremely Intense

4. PROBLEM DURATION: Approximately **how long** have you had the current problem? ____
5. COPING ATTEMPTS: In what ways have you **attempted to cope** with this problem? ____

____

____

6. EXPECTATIONS: What do you **hope to accomplish** by coming here? ____

____

____

Family Background

1. Have you been **married/partnered before**? Yes No If yes, when and for how long? ___________________________
2. Please list the names of your **children** or dependants.

Names of Children	Date of Birth	Age	Lives With You?
______________________________	______________	_____	Yes No
______________________________	______________	_____	Yes No
______________________________	______________	_____	Yes No
______________________________	______________	_____	Yes No
______________________________	______________	_____	Yes No

3. List **others who may live with you** including their ages and occupations (e.g. brother 16, student, mother-in-law 55, teacher; etc.)

____

____

4. Please check any past, present, or impending **special problems in your family**:

___deaths
___serious illness
___psychiatric disorder
___financial crisis/unemployment
___divorce
___debilitating injuries/disabilities
___physical/sexual abuse
___attempted/completed suicide
___frequent relocations
___alcohol/drug abuse
___legal problems
___eating disorders

___other ____

5. Please specify **family member(s), with special problems**, and approximate year of occurrence (e.g. mother, serious illness, 1998, etc.)

____

____

6. Would you like **anyone else** involved in the counseling with you? (family members, friends, etc.) ________________________________

____

7. Is there a concern about **violence** in your life today? Either from you or towards you? Please explain: ___________________________

____

How concerned are you on a scale of 1 to 10, with 10 being the worst ? (Circle one):

1 2 3 4 5 6 7 8 9 10

8. Have you personally experienced significant **family abuse**?
___none ___unsure ___emotional ___physical ___sexual

9. Have you personally experienced **legal problems**? ___NO ___YES

10. Did you experience **learning problems** in elementary or high school? (Check one):
___none ___little ___some ___substantial ___lots, constant struggle

11. In general, how **happy or adjusted** were you growing up? (Check one):
___poor ___unsatisfactory ___about average ___substantial ___completely

12. How much is your immediate family a source of **emotional support** for you? (Check one):
__none ___little ___somewhat ___substantial ___very strong

13. How much **conflict in values** do you currently experience with your parents? (Check one):
___very little or none ___some ___moderate ___strong ___extreme

14. Who in your family do you currently **feel closest** to? ____

Most **distant** from? ______________________________ In most **conflict** with? _______________________________________

15. If you are married or in a committed relationship, are you currently **in the process of separation or divorce**? Please specify:

____

What is the length of time apart? ____

What reason(s) have you given your children for the current problem? ____

____

How committed are you to making your marriage/relationship work? ____

____

What changes are you willing to make for the sake of your marriage/relationship? ________________________________

____

____

16. Describe any concerns regarding **sexual or emotional intimacy** with your spouse/partner. ___________________________________

____

____

17. Please list any **information that you believe will be helpful** for your therapist to know. ____________________________________
____
____
____

Health And Social Issues

1. How is your **physical health** at present? ___poor ___unsatisfactory ___satisfactory ___good ___very good

2. Please list any **persistent physical symptoms** or health concerns (e.g. chronic pain, diabetes, headaches, etc.)
____

3. Are you presently taking any **prescribed or non-prescribed medication** (antidepressants or others)? ___Yes ___No
Please indicate ____

4. Are you having any problems with your **sleep habits**? ___Yes ___No
If yes, check where applicable: ___sleeping too little ___sleeping too much ___poor quality sleep
___disturbing dreams ___other ____

5. How many times per week do you **exercise**? ___________________ For about how long each time? _________________

6. Are you having any difficulty with **appetite or eating habits**? ___Yes ___No
If yes, check where applicable: ___eating less ___eating more ___binging ___poor appetite
___making myself vomit ___significant weight change (last two months)

7. Do you regularly use **alcohol**? ___Yes ___No
In a typical month, how often do you have 4 or more drinks in a 24 hour period? _____________________________
Do you consider your alcohol consumption a problem? ___Yes ___No ___Unsure

8. How often do you engage in **recreational drug use**? ___daily ___weekly ___monthly ___rarely ___never
Do you consider this drug use a problem? ___Yes ___No ___Unsure

9. Do you have any problems or worries about **sexual functioning**? ___Yes ___No
If yes, check where applicable: ___lack of desire ___performance problem ___sexual impulsiveness
___difficulties maintaining arousal ___worried about sexually transmitted disease
___other ____

10. Have you ever experienced **sexual assault, unwanted sex or uncomfortable touching**?
___frequently ___a few times ___once ___never ___unsure

11. Have you had **suicidal thoughts** recently? ___frequently ___sometimes ___rarely ___never
Have you had them in the past? ___frequently ___sometimes ___rarely ___never

12. Have you ever intentionally inflicted any harm upon yourself? ___Yes ___No ___Unsure

13. In the past, how would you rate the quality of your **peer relationships**?
    ___very poor ___unsatisfactory ___about average ___good ___excellent

14. Approximately how many **significant intimate relationships** (e.g. lasting 6 months or more) have you been involved in?
    ___________________ Are you in one now? ___Yes ___No ___I think so

15. Besides family members, approximately how many people can you really count on right now for friendship or **emotional support**?
    ____

16. Additional Notes:

____
____
____
____
____
____
____
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____
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____
____

PLEASE SIGN BELOW TO INDICATE THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT:

CLIENT: ____ **DATE:** ____________________

17. ABOUT YOUR CONCERNS

Please check all the items below that you currently experience or having difficulty, and feel free to add any others at the bottom under "Other concerns or issues." You may add details as needed to clarify.

	Abortion		Grieving, mourning		Physical problems
	Abuse - emotional		Guilt		PMS
	Abuse - neglect		Headaches, pains		Poor self-care
	Abuse - sexual		Health, illness		Pornography use
	Adoption		Hearing voices		Procrastination
	Aggression		Hostility		Relationship problems
	Alcohol Use		Hyperactivity		Relaxation
	Ambition		Impulsive spending		Re-marriage
	Anger		Impulsiveness		Risk-taking
	Anxiety		Incest		Sadness
	Arguing		Indecision		School problems
	Attention problems		Inferiority feelings		Self abuse - burning
	Career concerns		Infertility		Self abuse - cutting
	Childhood issues		Inhibitions		Self abuse - other
	Children – care of		Interpersonal conflicts		Self abuse - scratching
	Children - custody		Irresponsibility		Self abuse – pulling hair out
	Children - management		Irritability		Self-centeredness
	Choices I've made		Judgment problems		Self-control
	Chronic pain		Laziness		Self-esteem
	Codependence		Legal matters, charges, suits		Self-neglect, poor self-care
	Communication		Loneliness		Separation
	Compulsive spending		Loss of control		Sexual addiction
	Confusion		Losses		Sexual conflicts
	Constant conflicts		Loss of interest in activities		Sexual desire differences
	Crying		Loss of interest in sex		Shyness
	Deaths		Low energy		Smoking
	Debt		Low frustration tolerance		Spirituality
	Decision making		Low income		Step-parenting
	Dependence		Low mood		Stress
	Depression		Marital conflict		Stress-management
	Distractibility		Marital distance		Suspiciousness
	Divorce, separation		Marital infidelity/affairs		Temper problems
	Domestic violence		Medical concerns		Tension / stress
	Drug abuse – over the counter		Memory problems		Thought disorganization
	Drug abuse - prescription		Menopause		Threats of violence
	Drug abuse – street drugs		Menstrual problems		Tiredness
	Drug abuse - alcohol		Mixed feelings		Tobacco use
	Education		Mood swings		Unhappiness
	Employment – lack of		Motivation		Violence
	Employment - overdoing		Mourning		Violence – victim of crime
	Employment problems		Nail-biting		Weight and diet issues
	Employment - termination		Nervousness		Withdrawal - isolating
	Emptiness		Nightmares		Work problems
	Exhaustion		Obsessions, compulsions		Worry all the time
	Failure		Outbursts		**Other concerns or issues:**
	Fatigue, low energy		Oversensitive to criticism		
	Fears, phobia		Oversensitive to rejection		
	Feelings of helplessness/hopeless		Overweight		
	Financial troubles		Panic or anxiety attacks		
	Friendship problems		Parenting		
	Gambling		Perfectionism		
	Gender identity		Pessimism		
	Goals not being met		Phobias		