INTAKE QUESTIONNAIRE – ADULT

Location: ☐ Lake Geneva Wellness Clinic, LLC
101 Broad Street Ste 201
Lake Geneva, WI 53147
Ph: 262-248-7942
Fax: 262-248-1202

☐ Wheatland Location
6606 368th Ave
Burlington, WI 53105

ABOUT YOU *Your response to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.*

Birth (Legal) Name:_____ Today's Date:____/____/_____
Preferred Name: _____
If you have had services here before, under what name?_____
Address:_____
City State Zip Code
Home Phone: _____ Work Phone:_____ Email:_____
Living Situation (who lives in your home with you): _____
_____
Your Birth Date:_____ Where were you born?_____ Marital Status:_____

Employer's Name :_____ Address:_____
City State Zip Code

Gender:_____ Preferred Pronouns:_____

Race/Ethnicity:

☐ White/Caucasian
☐ Asian
☐ Black/African American
☐ Hispanic or Latino
☐ American Indian or Alaska Native
☐ Native Hawaiian or Pacific Islander

Sexual Orientation: _____

Disability:
Do you have a disability? ☐ Yes ☐ No If yes, please specify: _____
If you have a disability, does the office accommodate your needs? ☐ Yes ☐ No
If no, please explain: _____

If you feel that the therapist should be aware of any special treatment considerations due to gender, age, sexual orientation or cultural, religious, national, racial or ethnic identity, please explain below:
_____
_____

Who referred you to the Wellness Clinic?_____

PLEASE LIST ANY SCHOOL AND COLLEGES YOU ATTENDED, ALONG WITH DIPLOMAS, DEGREES AND APPROXIMATE DATE OF AWARD

Name of School	**Diploma or Degree**	**Year(s)**

Military Service: ☐ NO ☐ YES **If Yes, Length of Duty _____** **Honorable Discharge** ☐ NO ☐ YES

Spirituality:
How Important Are Spiritual Matters To You?
☐ Not At All ☐ A Little ☐ Very Important

Are you affiliated with any spiritual or religious group? ☐ NO ☐ YES Describe _____

Would you like to discuss spiritual matters with your counselor in relation to helping with your present issues?
☐ NO ☐ YES ☐ Maybe

ABOUT YOUR SPOUSE OR SIGNIFICANT OTHER:

Check all that apply: ☐ Married ☐ Legally Separated ☐ Divorced ☐ Partner

If married or with a partner, how long have you been together?_____

Name of your significant other:_____ Is your significant other employed?_____
If so, where?_____

What does she/he do?_____

Do you have any concerns or questions about your significant other or relationship status that we should be aware of, or that you would like to discuss? ☐ Yes ☐ No

If yes, please briefly note them here:_____

ABOUT YOUR CHILDREN:

Do you have children: ☐ Yes ☐ No – If no, go to next section "Family History"

Names and age of children: (include stepchildren living with you)

Name	Age	Date of Birth

FAMILY HISTORY:

Is your father living?_____ If not, approximate date of death:_____
Do you have a healthy relationship with your father? ☐ Yes ☐ No
What was your father's occupation?_____

Is your mother living?_____ If not, approximate date of death:_____
Do you have a healthy relationship with your mother? ☐ Yes ☐ No
What was your mother's occupation?_____

Briefly describe the quality or nature of your relationship with your parents and note any questions or concerns you might wish to raise regarding that relationship: _____
_____
_____

Do you have siblings, including stepfamily? ☐ Yes ☐ No
Please list your siblings and their ages.

Name	Age	Name	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LEGAL HISTORY:

Have you had any involvement with the legal system: ☐ Yes ☐ No

Please describe any involvement you have had with the legal system (arrests, convictions, probation, parole):

_____
_____
_____
_____
_____

PRESENTING PROBLEM (current situation and history):

1. What is the primary problem for which you are seeking help? (please circle)

a. Marriage or relationship	g. Problems with children	m. Grieving
b. Family problems	h. Peer problems	n. Abuse or trauma
c. Depression	i. Eating disorder	o. Sexual functioning
d. Mood swings	j. Alcohol/drug use	p. Anger
e. Behavior	k. Physical problems	q. Anxiety or worry
f. Self-confidence	l. Work related	r. Other (explain):

_____
_____

2. How long have you had this/these problem(s)? _____

3. Have you received treatment for this problem or any other problem in the past? ☐ Yes ☐ No

Previous Mental Health Treatment

	YES/NO	When	Where	Outcome
Counseling?	☐ Yes ☐ No			
Psychiatric Treatment?	☐ Yes ☐ No			
Past/Current Diagnosis?	☐ Yes ☐ No			
Self Injury?	☐ Yes ☐ No			
Suicidal Thoughts?	☐ Yes ☐ No			
Suicide Attempt?	☐ Yes ☐ No			
Danger to Others?	☐ Yes ☐ No			

MEDICAL HISTORY:

Name of Primary Care Family Physician _____

Primary Care Family Physician's Address:_____

Date of last physical examination_____

List any past or present illnesses, infirmities or disabilities of any consequence: _____
_____

Please list significant hospitalizations, operations, injuries (including broken bones): _____

_____

All Medications You Are Taking (prescribed or otherwise):

_____
_____

***Please rate the severity of any current or recent (within the past 6 months) symptoms or problems by assigning either a 1,2,3,4 or 5 from the following scale:**

1- Very mild 2-Somewhat mild 3-Moderate 4-Somewhat Severe 5-Severe

_____a. anxiety, tension, nervousness	_____n. muscle tension/ spasticity/ cramps
_____b. coldness or numbness in fingers	_____o. heart palpitations or pounding
_____c. frequent or severe headaches	_____p. frequent worrying/ preoccupation
_____d. skin problems (i.e. rash, acne or dermatitis)	_____q. stiffness, aching or burning sensation in joints
_____e. frequent upset stomach/ indigestion/ nausea	_____r. lack of energy/ frequent fatigue or sluggishness
_____f. depression or crying spells	_____s. lack of appetite
_____g. chronic pain (specify_____)	_____t. excessive appetite
_____h. dizziness or fainting spells	_____u. shortness of breath/ rapid breathing
_____i. diarrhea or constipation/ urinary problems	_____v. problems with falling asleep
_____j. memory problems/ inability to concentrate	_____w. frequent wakening/ early wakening
_____k. excessive alcohol, drug or medication use	_____x. excessive energy/ hyperactivity
_____l. excessive caffeine use (e.g. coffee, tea, chocolate, soda)	_____y. sexual functioning problems
_____m. high blood pressure/ hypertension	_____z. irritability/ temper control problems
	_____ Other:_____

HISTORY OF TRAUMA:

Have you ever been molested or sexually abused? ☐ Yes ☐ No

Have you faced any trauma in your life, physically, verbally or emotionally…? If Yes, Please Explain:

_____
_____
_____
_____

DEVELOPING A TREATMENT PLAN:

1. What are your strengths? _____

_____

2. What are your weaknesses? _____

_____

3. Rate your current overall Wellness (1 = the lowest, 10 = your best) _____

4. What goals would you like to see reached as a result of therapy?

_____

_____

_____

5. What level of improved Wellness would you like to achieve? (scale of 1 – 10) _____

6. How will you know when these goals have been reached?

_____

_____

7. If the problem that caused you to seek help were to be gone tomorrow, how would your life be different?

_____

_____

_____

THERAPIST REVIEW

Signature: Date: