Acme Counseling and Consulting Services * Valerie Peckham, LCP
Adult Admission Questionnaire

Please complete this questionnaire and bring it with you to your first appointment. Please answer all the questions truthfully and to the best of your knowledge as your answers help me develop my understanding of how to best meet your needs. Please do not leave anything blank or incomplete. If a question does not apply to you, please mark it with NA. The information you provide is confidential and protected as such by law.

DEMOGRAPHIC INFORMATION:

Full Name: _____

Name you prefer to be called: _____ Gender: _____

Birth Date: _____ /_____ /_____ Age: _____ Race/Ethnicity: _____

Full Address: _____

Cell Phone: ( ) _____May we text and/or leave messages? □ Yes □ No

Home Phone: ( )_____May we leave messages? □ Yes □ No

Other Phone: ( )_____May we text and/or leave messages? □ Yes □ No

E-mail: _____May we email you? □ Yes □ No

Please note: Text and Email correspondence is not considered to be a confidential medium of communication. Clinical issues will not be discussed through text/email.

Would you like to receive appointment reminders via text _____ and/or email _____ ? Initial for Consent _____

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Emergency Contact Name, Relationship, and Phone #:

_____

Please note: This information will only be utilized in emergency situations unless you authorize contact in writing.

CURRENT NEEDS FOR TREATMENT:

How did you find us or who referred you: _____

Reason for being here: What brings you to seek counseling/therapy at this time? Please give a brief description of what's been happening and why you are wanting or needing some extra help:

CURRENT NEEDS FOR TREATMENT (CONTINUED):

Please review this list and note any current or recent symptoms, concerns, or experiences with an '**X**'. If you like, you may note minor/mild concerns with '**M**' and severe/intense concerns with '**S**'**.**

___ Sadness	___ Depressed mood	___ Elevated mood
___ Grief	___ Unable to enjoy or have fun	___ Sleep pattern change or disturbance
___ Irritability	___ Crying more than usual	___ Appetite or eating habits change
___ Anger	___ Impulsivity	___ Change in libido or sexual interest
___ Anxiety	___ Apathy or loss of interest	___ Sense of racing thoughts
___ Worry	___ Fatigue or decreased energy	___ Increased or excessive energy
___ Guilt	___ Attacks of panic or anxiety	___ Increase in risky behavior
___ Low self-worth	___ Difficulty concentrating	___ Increase in talkativeness
___ Forgetfulness	___ Decrease in activity	___ Increase in activity
___ Fears or phobias	___ Intrusive or undesired thoughts	___ Avoidance of important people, places, events
___ Nightmares	___ Unpleasant memories	___ Uncontrollable behaviors
___ Flashbacks	___ Feeling jumpy or easily startled	___ Feeling restless or keyed up
___ Hypervigilance	___ Feeling detached or estranged	___ Difficulty remembering important experiences
___ Procrastination	___ Unable to feel emotions	___ Black outs or losing time
___ Fidgeting	___ Poor follow through on tasks	___ Unexplained physical symptoms
___ Hallucinations	___ Distorted perceptions	___ Difficulty in relationships
___ Indecisiveness	___ Thoughts of death	___ Thoughts of suicide
___ Agitation	___ Thoughts of self-harm	___ Thoughts of homicide
___ Hyperactivity	___ Feeling inhibited	___ Feeling out of control
___ Shame	___ Other: _____	___ Other: _____

How long have you been experiencing these symptoms/concerns?

How distressing are the symptoms/concerns to you or to others?

What impacts/impairments have these symptoms/concerns caused for you (missed work, etc)?

What are your most significant life events, changes, or stressors that have occurred in the last 6-12 months?

Have you ever experienced a traumatic event (i.e. abuse of any kind, natural disasters, accidents, sudden losses, violence, etc.)? □ No □ Yes—If yes, please describe:

What experiences or events have been the most impactful or pivotal in your life?

CURRENT NEEDS FOR TREATMENT (CONTINUED):

Are you currently or have you recently had thoughts of self-harm or suicide? □ No □ Yes—If yes, please describe any plans considered:

Do you have any history of engaging in self-harming behavior? □ No □ Yes—If yes, please describe:

Do you have any history of suicide attempts? □ No □ Yes—If yes, please describe:

Are you currently or have you ever experienced times when you heard or saw things that other people may not have? □ Never □ In the past but not presently □ Within the last 2 weeks, please describe:

FAMILY HEALTH HISTORY: In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please circle yes or no:		List any/all family member(s)
Alcohol/Substance Abuse	yes/no	_____
Anxiety	yes/no	_____
Depression	yes/no	_____
Domestic Violence	yes/no	_____
Eating Disorders	yes/no	_____
Obsessive-Compulsive	yes/no	_____
Schizophrenia	yes/no	_____
Suicide Attempts	yes/no	_____
ADHD (AKA: ADD)	yes/no	_____
Diabetes	yes/no	_____
Heart Disease	yes/no	_____
Thyroid	yes/no	_____
Cancer	yes/no	_____
Other:_____	yes/no	_____

PERSONAL HEALTH HISTORY AND INFORMATION:

Have you ever sought counseling or therapy in the past? □ No □ Yes—If yes, please describe the reason/circumstances:

PERSONAL HEALTH HISTORY AND INFORMATION (C0NTINUED):

If you previously received any type of outpatient mental health services (counseling, therapy, medication, etc.), please list the reason, names of providers, and dates of service:

Reason for treatment	Name of Provider	Start and End Date

Have you previously received any type of inpatient mental health services (psychiatric hospitalization, residential placement, rehab, etc.)? □ No □ Yes, please note date and location of hospitalization(s):

Reason for treatment	Hospital/Treatment Facility	Dates of Treatment

How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

CONDITION	DIAGNOSED AND TREATED BY:	EFFECTIVELY MANAGED? Y OR N

How many times per week do you generally exercise? _____
What types of exercise to you participate in?

Are you currently experiencing any chronic or repeated pain? □ No □ Yes—If yes, please describe:

PERSONAL HEALTH HISTORY AND INFORMATION (C0NTINUED):

Are you currently taking any prescription medication? □ No □ Yes, Please complete the following:

Name of Medication	Prescribed Dosage	Compliant? Y or N	Prescribed by:	Prescribed for:

Have you ever been prescribed psychiatric medication (medication for mental health or emotional management)?
□ No □ Yes—If yes, please complete the following:

Name of Medication	Date Discontinued	Reason Discontinued	Prescribed by:	Prescribed for:

LEGAL HISTORY AND INFORMATION:

Have you ever been detained or arrested by law enforcement? □ No □ Yes—If yes, please describe:

Have you ever been charged with or convicted of a misdemeanor of felony offense? □ No □ Yes—If yes, please describe:

Are you currently under parole or probation supervision? □ No □ Yes—If yes, please describe:

Are there any pending legal cases against you? □ No □ Yes—If yes, please describe:

Do you have any habits or patterns of law-breaking without being caught?

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SUBSTANCE RELATED HISTORY AND CONCERNS:

Do you use tobacco? □ No □ Yes—If yes, please describe:

Do you consume caffeine? □ No □ Yes—If yes, please describe:

Do you CURRENTLY drink alcohol more than once a week? □ No □ Yes If yes, how much do you drink and how often?

Have you or has someone else ever thought or suggested that you may have a problem with alcohol? □ No □ Yes—
If yes, please describe concerns:

Have you ever engaged in recreational drug use (illicit or prescription)? □ No □ Yes—If yes, please describe:

How often do you CURRENTLY engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

Drug used	Amount used	Cravings/withdrawal without use? Y or N

Have you or has someone else ever thought or suggested that you may have a problem with drugs? □ No □ Yes—If yes, please describe concerns:

Have you ever experienced any legal ramifications for drug or alcohol use? □ No □ Yes, please describe:

Have you ever participated in drug or alcohol treatment? □ No □ Yes, please describe:

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SOCIAL INFORMATION:

Where do you live and what is your current living situation?? (i.e. in a house or apartment… homeless? Living alone, with parents, with family, with pets, etc.)

What is your current romantic relationship status?

If you have a romantic partner, how long have you and your partner been together?

If you are married, how long?

What is your current level of satisfaction in this relationship on a scale of 1-10 (10 being most satisfied)? _____
Please expand on your rating:

Is there any history of violence in this relationship? □ No □ Yes—If yes, please describe:

Please note any other current romantic relationships:

Please note any other significant past romantic relationships or marriages:

If you are a parent, please list the following about your children:

NAME	AGE	LIVING WITH YOU: Y OR N

If you have minor children who are not living with you, please describe the circumstances:

How would you rate your current satisfaction in your relationships with your children on a scale of 1-10 (1 being unsatisfying and/or no contact, 10 being very satisfying and involved) _____?

Any additional info about your children you would like to share:

SOCIAL INFORMATION (CONTINUED):

How would you rate your current satisfaction with family of origin relationships on a scale of 1-10 (1 being not helpful and no contact, 10 being very helpful and involved)? _____

Who raised you and where did you live growing up?

If you have siblings, please list the following:

NAME	AGE	RELATIONSHIP (half, whole, step, maternal/paternal side?)

What were your most significant family events growing up? (i.e adoption, parents' divorce, death of a significant loved one, family move/relocation…?)

Please note any specific concerns or any significant current or historical information about members of your family of origin (i.e. feuds, estrangements, etc.):

How would you rate your satisfaction in your social support network (friends) on a scale of 1-10 (1 being not helpful and no contact, 10 being very helpful and involved)? _____

Any specific concerns or significant history regarding your interactions with friends and/or peers (i.e. difficulty making/keeping friends, history of bullying, shyness/insecurity…)?

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DEVELOPMENT AND EDUCATION:

To your knowledge, were there any concerns or issues with your development during childhood? For example, were there problems reaching developmental milestones (walking, talking, toileting) or did you receive any special services or an IEP in school? □ No □ Yes—If yes, please explain:

Please mark the level(s) of education you have completed:

□ GED □ High School □ Associates Degree □ Bachelor's □ Master's □ Doctorate □ Trade/Tech School

If you completed any college degrees or a trade/tech programs, what were your areas of study?

OCCUPATION/CAREER

Are you currently a student or employed? □ No □ Yes—If yes, what is your current student/employment situation—(Full-time/Part-time and name of employer/school with length of study/employment):

Do you enjoy your studies/work?

Is there anything stressful about your current study/work?

SPIRITUALITY/RELIGION

Do you consider yourself to be spiritual or religious? □ No □ Yes—If yes, describe your faith or belief:

Are your spiritual beliefs something you would prefer to incorporate into your treatment? □ No □ Yes

TREATMENT RESOURCES:

What do you consider to be some of your personal strengths?

What do you consider to be some of your limitations or weaknesses?

What coping skills, resources, etc. have you tried thus far to help with your primary concerns and what effects have you observed?

What do you like to do for fun and enjoyment (hobbies, sports, etc.)? When did you do it last?

What are 3 goals/areas you would like to work on in therapy and in what time frame would you like to accomplish them?

1.
2.
3.

Time frame:

Is there anything else you would like to say or you want me to know?