

Introductory Questionnaire

PLEASE PRINT FORM, FILL OUT, AND BRING TO FIRST APPOINTMENT

This questionnaire is designed to build a foundation for therapy. By responding to these questions as thoroughly as you can, you will be:

- *Gathering basic information more efficiently and effectively*
- *Helping me get to know you in a more focused way*
- *Providing a historical background for present concerns*
- *Directing attention to key areas*
- *Clarifying current concerns*
- *Preparing to develop a therapeutic plan*

Your responses are strictly confidential, and protected by law to the extent of the law. No portion of this document will be released to others without your permission, except if required by law.

If you have any questions, please feel free to ask. Some questions may not pertain to you. If there is a question you do not wish to answer in writing, just let me know.



Luann Adams
RN ACSW LMFT
Clinical Member, AAMFT
628 North Main Street
Royal Oak, MI 48067
248.546.0079

luann@luannadams.com
www.luannadams.com

General Information

Name _____ DOB _____ Age _____

Address _____ City _____ Zip _____

Phone _____ Phone (alternate) _____

Email _____ Preferred method of contact? _____

How were you referred? _____

Your Occupation _____

Your Employer _____

Current Marital Status _____

Spouse's Name _____ DOB _____ Age _____

Spouse's Occupation _____

Spouse's Employer _____

Emergency Contact _____ Phone _____

Do you have children? Y__ N__ Stepchildren? Y__ N__ Grandchildren? Y__ N__

Children's Names _____ Gender _____ Age _____

_____ Gender _____ Age _____

_____ Gender _____ Age _____

_____ Gender _____ Age _____

_____ Gender _____ Age _____

Stepchildren's Names _____ Gender _____ Age _____

_____ Gender _____ Age _____

_____ Gender _____ Age _____

Grandchildren's Names _____ Gender _____ Age _____

_____ Gender _____ Age _____

_____ Gender _____ Age _____

Description of present problems

Please state in your own words the nature of your main concern(s): _____

Please indicate how distressing your concern is right now:

Mildly upsetting Moderately upsetting Very upsetting Extremely upsetting Totally upsetting

When did this concern begin? Give dates if possible: _____

Please describe any important events at that time or since then which may have started the concern or that keep it going: _____

In what ways have you tried to resolve this concern? _____

In what ways was that helpful? _____

What obstacles remain? _____

Have you been in therapy before or received any prior professional or support group assistance for your concern? _____ If so, what was helpful at that time? _____

Family of origin history

Number of brothers _____ Ages _____ Married? ____ Children? __

Number of sisters _____ Ages _____ Married? ____ Children? __

Other significant family of origin members _____

Father's history

Living? Y ____ N ____ Age _____ Health _____ Birth Father? _____

Occupation _____

If deceased:

What was his age and cause of death? _____

What was your age at the time of his death? _____

Indicate any mental or physical difficulties your father has or has had:

Depression	Anxiety	Mental Illness	Physical Illness
Relationship Problems	Drinking Problems	Drug Problems	Suicidal Thoughts/Attempts
Spiritual Problems	Financial Problems	Gambling Problems	Problematic Internet Use
Anger Management Problems			

Other _____

Mother's history

Living? Y ____ N ____ Age _____ Health _____ Birth Mother? _____

Occupation _____

If deceased:

What was her age and cause of death? _____

What was your age at the time of her death? _____

Indicate any mental or physical difficulties your mother has or has had:

Depression	Anxiety	Mental Illness	Physical Illness
Relationship Problems	Drinking Problems	Drug Problems	Suicidal Thoughts/Attempts
Spiritual Problems	Financial Problems	Gambling Problems	Problematic Internet Use
Anger Management Problems			

Other _____

Parents' history

Are your parents currently married? _____ If no, has either of your parents remarried? _____

Was either parent previously married? _____

Spiritual history

Your religious affiliation as a child _____ As an adult _____

Current church affiliation _____ Pastor's name _____

How would you describe your current spiritual/religious life? _____

In what ways is this a personal strength for you? _____

Would you like to explore spiritual matters in more detail? YES NO NOT SURE

Nationality

Does your family affiliate with a nationality or country of origin? _____

If yes, please describe: _____

In what ways is this a personal strength for you?

Childhood and Adolescence

Circle any of the following that applied during your childhood or adolescence:

happy childhood unhappy childhood emotional problems eating disorder
family problems physical abuse alcohol abuse sexual abuse legal problems
drug abuse school problems medical problems financial problems abortion
other _____

If you were not raised by your parents, who helped raise you? _____

Between what ages/years? _____

Please describe your **father's** (or father substitute's) personality and his methods of discipline (past & present): _____

How did he show affection and how often did he share his affection with you? _____

In what ways did he influence you or others members of the family? _____

Please describe your **mother's** (or mother substitute's) personality and her methods of discipline (past & present): _____

How did she show affection and how often did she share her affection with you? _____

In what ways did she influence you or others members of the family? _____

What were the prevailing emotional overtones in your family while you were growing up? _____

Has any close relation had significant problems? _____ If yes, please describe: _____

Has any close relation expressed suicidal thoughts? _____ Behaviors? _____ If yes, please describe: _____

Has any relative had serious problems with the law? _____ If yes, please describe: _____

Physical

What is your height? _____ Weight? _____

Do you have or have you ever had any of the following? (Please describe):
Illnesses or physical conditions _____

Surgeries _____

Unusual physical characteristics _____

Unusual sensations _____

Troubling physical symptoms _____

Other _____

Current medications: _____

Prescribed by: _____

Allergies: _____

Name and phone number of your family physician: _____

Most recent full physical examination: _____

Results: _____

How would you describe your overall health? _____

Educational

Please list the last completed grade/degree(s) in school: _____

Specialized areas of study: _____

Current educational activities: _____

Occupational

What sort of work are you currently doing? _____

Does your present work satisfy you? _____ Please describe: _____

What were your past ambitions or dreams? _____

What are your current ambitions or dreams? _____

What kinds of hobbies or leisure do you enjoy or find relaxing? _____

Financial

What is your household income? _____

How much does it cost you to live? _____

Do your concerns include financial issues? If so, please describe: _____

Behavioral

Please circle and describe any of the following behaviors that apply to you:

overeating
aggressive behavior
lying pattern
nervous tic
loss of control
laziness
use of drugs
take too many risks
crying
concentration difficulties

odd behavior
problematic sexual behavior
worrying
insomnia
procrastination
drinking too much
can't keep a job
impulsive reactions
withdrawal
gambling

phobic avoidance
passive behavior
vomiting
outbursts of temper
smoking
working too much
compulsions
food use problems
sleep disturbance
problematic internet use

other _____

Have you been hospitalized for psychological or emotional problems? _____

If so, when and where? _____

Menstrual history

Age of first period _____ Were you knowledgeable or was it a surprise? _____

Are your periods regular? _____ Do you experience pain? _____

How does your cycle affect your mood? _____

Sexual

Please describe your parents' attitude toward sex: _____

Was sex discussed in your home? _____

When and how did you derive your first sexual knowledge? _____

When did you first become aware of your own sexual impulses? _____

Have you experienced anxiety or guilt feelings arising out of sex or masturbation? _____

If yes, please describe: _____

Are your first or subsequent sexual experiences relevant? _____ In what way? _____

Is your present sex life satisfactory? _____ Please describe: _____

Have you experienced significant homosexual thoughts or relationships? _____

Please describe any sexual concerns not discussed above: _____

Your current family

Whom do you include in the group you consider your current "family"? _____

How would you describe your current family? _____

What are the prevailing emotional overtones in your current family? _____

Marriage

How long did you know your spouse before your engagement? _____

How long were you engaged? _____

How long have you been married? _____ Previously married? _____

If previously married, for how long? _____ How soon were you remarried? _____

Was your spouse previously married? _____ If so, for how long? _____

How soon was he/she remarried? _____

How would you describe your relationship with your spouse?

Children

Please, describe your methods of discipline (past and present): _____

Please, describe your spouse's and/or parenting partner's methods of discipline (past and

present): _____

Do any of your children present special problems? _____ Please describe: _____

Family Life

How do you show affection and how often do you share affection with your family (past and present)? _____

In what ways do you influence other members of your family? _____

How does your spouse show affection and how often do they share affection with others in your family (past and present) ? _____

In what ways does your spouse influence you and other members of your family? _____

Friendships

Do you make friends easily? _____

In what ways are your friendships important to you? _____

To whom would you be most likely to turn for help? _____

Please, rate the degree to which you generally feel comfortable and relaxed in social situations:

Very relaxed

Relatively comfortable

Relatively uncomfortable

Very anxious

Stress

Check and describe any of the following that apply and indicate the person involved such as a spouse, child, father, mother, brother, sister, yourself, etc. Please indicate those you consider important.

Death in the family _____

Miscarriage _____

Divorce _____

Trouble with the law _____

Financial trouble _____

Job/School problems _____

Geographic relocation _____

Serious illness _____

Serious operation _____

Abortion _____

Mental illness _____

Alcohol problems _____

Drug problems _____

Interpersonal problems _____

Physical abuse _____

Sexual abuse _____

Depression _____

Suicidal thoughts _____

Suicidal attempts _____

Spiritual problems _____

Anger management problems _____

Unresolved conflict _____

Other _____

Systems outside of your immediate family

How do you relate with your in-laws? _____

Have your parents, relatives, or friends sought to influence your situation? _____

Please describe: _____

Is your job or school situation unusually stressful? _____

Please describe: _____

Has your pastor, priest, or other clergy made a special effort to talk with you about your _____

situation? _____ Do you consider him/her available to you in this life situation? _____

Please describe: _____

Have the police or other social agencies influenced your family? _____

Please describe: _____

Have there been any other significant outside influences on your family? _____

Please describe: _____

Expectations regarding therapy

In a few words, what do you think therapy is all about? _____

How long do you think therapy should last? _____

How do you think a therapist should interact with clients? _____

What personal qualities do you think the ideal therapist should possess? _____

How would you describe a desired outcome for therapy? _____

Please use this area to describe any other related matters you may have that have not been addressed by this questionnaire. _____

Please be sure to read the attached consent form. We will sign it together when we meet.

CONSENT FOR TREATMENT AGREEMENT

Client name (please print): _____

I, the undersigned, hereby attest that I am voluntarily seeking therapy with Luann Adams. I understand that either party may discontinue the therapeutic relationship at any time.

NON-VOLUNTARY DISCHARGE FROM TREATMENT

Treatment may be terminated non-voluntarily if the client exhibits physical violence or verbal abuse, carries weapons, or engages in illegal acts. Treatment may also be discontinued if the client does not participate actively in the therapy process. The client will be notified of the non-voluntary discharge verbally and/or by letter. Referral options may be discussed at the client's request.

OFFICE POLICY

I, the undersigned, may cancel or reschedule an appointment by calling 248.546.0079 (24 hours a day). I will give 24 hours notice of the need to cancel or reschedule my appointment. In lieu of 24 hours notice, I will be responsible for a \$75 late cancellation fee.

I, the undersigned, agree and acknowledge that I am responsible for full payment of services rendered. Payment for sessions will be made at the time of service unless other arrangements have been made. Insurance reimbursement, if available, will be discussed at my request.

CONFIDENTIALITY

Confidential client records are maintained by the therapist, and are protected by law. Session contents are held in confidence and will not be released without the client's permission except where required by law, or in a medical emergency.

Information concerning child abuse or neglect, frail elder abuse, or threat of homicide or suicide is not protected by law, and must be reported to appropriate authorities. Further, it is the therapist's duty to warn any potential victim when threat of harm has been made.

My signature below indicates that I have read and understand the provisions of this document.

Signature of client/legal guardian(s):

_____ Date _____

_____ Date _____

Witness:

_____ Date _____