BetsyGiduz LCSW, MSW, MSRA

ADULT INTAKE QUESTIONNAIRE

Date ____________________

Full Name __________________________________ ☐Male ☐Female Birthdate _____________

Address____

Street City State County Zip

Phones:

Home ___________________ May I leave a message w/a person? ☐Y ☐N Voicemail? ☐Y ☐N

Cell ___________________ May I leave a message w/a person? ☐Y ☐N Voicemail? ☐Y ☐N

Work ___________________ May I leave a message w/a person? ☐Y ☐N Voicemail? ☐Y ☐N

Email ______________________________________

Occupation, Employer ____

Emergency Contact Name ________________________________ Phone _______________

Will you be financially responsible for these services?

☐Yes ☐No If no, please list responsible party.

Name ______________________________________ Relationship to Client __________________

Address____

Phones:

Home ___________________

Cell ___________________

Work ___________________

Email ______________________________________

Occupation, Employer ____

107 Ellsworth Place, Chapel Hill, NC 27516
919-967-1036
betsygiduz@gmail.com

HEALTH INFORMATION

Current Medical Problems: ☐Yes ☐No If yes, briefly explain:

____

____

Allergies? ☐Yes ☐No If yes, please list:

____

Sleep problems? ☐Yes ☐No If yes, briefly explain:

____

Name of Primary Care Physician: ______________________________

Last Physical Exam Date and Results:

____

____

Are you taking any medications? ☐Yes ☐No If yes, please list:

____

Name of Prescribing Doctor: ______________________________

Have you ever been under the care of another mental health provider? ☐Yes ☐No

If yes, please elaborate:

____

____

What did you like about your last therapist?

____

____

What would you change about your last experience in therapy?

(I.e., what could have made it more beneficial to you?)

____

____

FAMILY INFORMATION

Marital Status: ☐Single ☐Married ☐Separated (Date________) ☐Divorced (Date________)
If Married, Name of Spouse ___________________________________

Do you have any children? ☐Yes ☐No
Who has physical custody?______________________ Legal custody?____________________

If you share custody of your children, please describe the current arrangement, including visitation:

____
____

List all people living in your home:

Name	Age	Relationship	Current Health	Comments
________________________	____	________________	Good Fair Poor	____________________
________________________	____	________________	Good Fair Poor	____________________
________________________	____	________________	Good Fair Poor	____________________
________________________	____	________________	Good Fair Poor	____________________
________________________	____	________________	Good Fair Poor	____________________
________________________	____	________________	Good Fair Poor	____________________
________________________	____	________________	Good Fair Poor	____________________

Your Parents' Marital Status: ___________ Year of separation/divorce, if applicable________

Has any other member of your immediate family (parents, siblings, grandparents, first cousins) had mental health treatment? ☐Yes ☐No If yes, please elaborate:

____
____
____

FAMILY RECORD *Indicate with a checkmark the condition and relationship of any blood relative who has or has had any of the conditions listed below.*	None	Client	Father	Mother	Grandfather	Grandmother	Brother	Sister	Other	Indicate Other Relative
Alcoholism/substance abuse										
Allergies										
Anxiety Disorder										
Attention/ADHD Problems										
Birth Defects										
Depression										
Developmental Disorder										
Diabetes										
Eating Disorder										
Learning Disorder										
Migraines										
Mental Illness										
Obsessive-Compulsive Dis.										
Seizure Disorder										
Sensory Issues										
Thyroid Problems										
Tic Disorder										
Other:										

Other Comments:

____

____

AREAS OF CONCERN

Please provide a brief description of how you think I could best help you and your family.

____

____

____

____

____

____

____

Other Comments:

____

____

____

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