Lorelei A. O'Neill,
Licensed Marriage & Family Therapist
Professional Corporation

Adult Questionnaire

Name _____ Date _____
Address _____
City & Zip _____
Home Phone _____ Work Phone _____
Client's Age _____ Date of Birth _____ Ethnicity _____
Social Security No. _____
Occupation _____ Employed Yes/No How Long _____
Monthly Household Income $_____ # in Household _____
Currently in School Y/N (Full/Part Time) Highest Completed Grade _____

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Relationship Status S/M/D/W How Long _____
Spouse's name (if applicable) _____
Number of Pregnancies _____ Number of Children _____
Children's Ages, Gender and Names:
_____
_____
Do all the children reside with you? If not, where do they live and how often do you see them: _____
_____

Check the problem areas that are leading you to seek counseling:

Marital	___	Emotional	___	Alcoholism or Drinking Problem	___		
Family	___	Financial	___	Personal Relationships	___		
Legal	___	Employment	___	Parental Issues	___		
Sexual	___	Drug Abuse	___	Major Stressor	____	Other	____

Please write a brief statement of your current problem: _____
_____
_____

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Family History – Indicate if any of the following is true for yourself or a family member

	Self	Mother	Father	Sibling	Grandparent
Depression	___	___	___	___	___
Suicide	___	___	___	___	___
Suicide Attempt (#)	___	___	___	___	___
Alcohol Problem	___	___	___	___	___
Drug Problem	___	___	___	___	___
Mental/Emotional Problem	___	___	___	___	___
Abuse	___	___	___	___	___

Medical History – Circle all of the following which you have now or had in the past

Heart Trouble	Frequent/Severe Headaches	Head Injury
Diabetes	High Blood Pressure	Fainting/Dizziness
Stroke	Shortness of Breath	Stomach Problems
Kidney Trouble	Bedwetting/Soiling	Epilepsy/Convulsions
Back Problems	Unusual Bleeding	Asthma/Hay Fever
Arthritis	Sleep Difficulty	Mood Changes
Cancer	Thyroid Trouble	Neurological Disease

Any other serious illness(es) or surgery:_____
_____

Name, address & telephone # of physician:_____
_____

Date of Last Exam _____ General Health _____

List all medications you are now taking (including prescription and non-prescription):

Medication/Strength	Dosage per Day	Prescribed By
_____	_____	_____
_____	_____	_____
_____	_____	_____

Prior Psychotherapy – Have you consulted a therapist of any type in the past Yes/No

Name	Address	Dates of Service
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been hospitalized for psychiatric reasons in the past? Yes/No

Hospital	Address	Dates of Hospitalization
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please provide people we can contact in case of an emergency

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____

Appointment Cancellations

If an appointment is cancelled or missed **without 24 hours prior notice**, a regular charge will be made. Monday appointments must be cancelled by noon on the preceding Friday.

Whom may we thank for referring you to us? _____

This form was completed by _____ on _____
Name Date