



Atlanta Educational Consultants

Young Adult Intake Questionnaire

Name: _____

Today's Date: _____

Age: _____ Date of Birth: _____

Address: _____

Home phone: _____

Work phone: _____

Cell phone: _____

Email: _____

Parents' Information

Mother: _____

Father: _____

Mother Cell: _____ Father Cell _____

Address(es): _____

Home phone(s) _____

Mother's email: _____

Father's email: _____

REASON FOR REFERRAL / CURRENT SYMPTOMS/Issues

Please describe the problems you are now having and the type of services you are seeking. _____

Present psychological difficulties – please check any that apply to you at this time.

Generalized Anxiety (across many situations)

___ Specific fears/phobias (list): _____

- ___ Panic attacks
- ___ Social Anxiety
- ___ Obsessive thinking or compulsive behaviors
- ___ Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)
- ___ Sadness or Depression
- ___ Emotionally overwhelmed
- ___ Frequent crying
- ___ Loss of energy
- ___ Loss of pleasure in life
- ___ Self-injurious / Self-harm behavior
- ___ Thoughts of suicide
- ___ Problems with eating
- ___ Problems falling
- ___ Emotionally overwhelmed
- ___ Frequent crying
- ___ Loss of energy
- ___ Loss of pleasure in life
- ___ Self-injurious / Self-harm behavior
- ___ Thoughts of suicide
- ___ Problems with eating
- ___ Problems falling asleep
- ___ Problems sleeping through the night (middle of the night waking or early morning waking)
- ___ Trouble waking up
- ___ Fatigue/tiredness during the day

- ___ Nightmares
- ___ Problems with attention or concentration
- ___ Racing thoughts
- ___ Problems making or keeping friends
- ___ Problems controlling temper
- ___ Relationship/Marriage problems
- ___ Problems with intimacy
- ___ Problems with job
- ___ History of abuse (emotional, physical, sexual)
- ___ Alcohol/drug use/abuse
- ___ Financial problems
- ___ Legal situation
- ___ Other:

Describe any previous mental health services you have received (evaluations and therapy). Include the provider, any diagnoses, and length of treatment.

What do you wish to accomplish (what are your goals) in seeking services at this time?

FAMILY INFORMATION: (May be N/A for Young Adult)

Marital Status (check one):

Single Living with Partner ___ Married ___ Separated ___ Divorced ___
Widowed ___

Rate quality of present relationship/marriage (if applicable):

___ very good ___ good ___ fair ___ poor ___ very poor

Your occupation: _____

Occupation of Spouse/Partner: _____

Children and ages: _____

If divorced, what are the custody arrangements? _____

Who currently resides in your home? _____

GENERAL HEALTH:

Your current health: _____ excellent _____ good _____ fair _____ poor _____

Primary Physician's name/address/phone number:

When was your last physical exam? _____ Any relevant findings?

Are there any other physicians you see on a regular basis?

Describe any medical conditions that you have been diagnosed as having and any medical procedures you have had (surgeries, etc.).

List any medications (and the dosages) you take regularly. Include your prescriptions, over the counter medicines, vitamins, and supplements.

Any problems with sleep? Describe.

Any problems with eating? Describe.

Please rate the overall level of stress in your life:

Very Low ____ Low ____ Average ____ High ____ Very High

What do you consider to be the greatest source of stress at this time?

Rate your overall level of happiness on a scale of 1-5 (1 = UNHAPPY, 5 = HAPPY).

Are you a past or present smoker? _____

Length of time, number of cigarettes and frequency: _____

Do you use alcohol? ____ Number of drinks and frequency: _____

Do you use Marijuana or other drugs? _____
(note this is kept completely confidential)

Do you drink caffeinated beverages? ____ Number of drinks and frequency:

FAMILY HISTORY:

Has anyone in the birth family had any of the following psychological disorders?
Check all that apply and list who (self, mother, father, sibling, child):

- Mental Retardation _____
- Speech or Communication Disorder _____
- Attention-Deficit / Hyperactivity / Impulsivity _____
- Learning Problems / Disabilities _____
- Autism Spectrum / Asperger's Disorder _____
- Sleep disorders _____
- Generalized Anxiety (across many situations) _____
- Social Anxiety _____
- Obsessive-Compulsive Disorder _____
- Phobias _____
- Depression _____
- Manic-Depression / Bipolar Disorder _____
- Suicide attempts / Suicide _____
- Schizophrenia or other psychosis _____
- Alcohol / Substance Abuse _____
- Seizures or other neurological disorder _____
- Genetic Disorder (e.g., Down Syndrome, Fragile X) _____

EDUCATIONAL HISTORY:

Your highest level of education completed: _____

Any problems with attention, learning, or behavior in school?

Grades repeated and reason: _____

Served in Special Education? _____

High School Attended: _____

Date of Graduation _____ GPA _____

SAT/ACT Scores: ACT overall _____ SAT Overall _____

SAT Verbal _____ SAT Math _____ SAT Writing _____

College Attended _____

Dates of attendance _____

GPA _____ Major Concentration _____

Academic suspension or probation: Yes _____ No _____

Eligible to return? Yes _____ No _____

Additional Comments: _____

Interests

What are you most interested in?

List any extracurricular activities, including sports, clubs, hobbies, lessons, etc. _____

Describe your strengths, positive qualities, and any special abilities or skills.

What do you see as your best qualities? _____

What are your greatest problems or handicaps? _____

What are your goals? _____

Describe your peer relationships _____

Religious preference (Optional) _____

LEGAL HISTORY

Have you every filed or been involved in any litigation? Please explain.

Referred by: _____

May we acknowledge the referral? _____