

Tracey Galgoci Counseling, PLLC
Adult Intake Questionnaire

The purpose of this questionnaire is to obtain an understanding of your life experience and background. Completing these questions fully and accurately will benefit you through the development of a treatment plan suited to your specific needs.

Date: _____

Name: _____

Email: _____

Address: _____

Zip Code: _____

Phone #: _____

Date of Birth: _____

Age: _____

Emergency contact person: Name _____ Phone _____

Highest level of Education: _____

Relationship Status:

Single Engaged Married Separated Divorced Committed relationship Widowed

Sexual Orientation:

Heterosexual Gay Lesbian Bisexual Transgendered Queer Additional category: _____

Preferred Pronouns:

She/her/hers They/them/theirs
 He/him/his Other: (please specify: _____)

Employer: _____ **Job Title:** _____

Medical History:

1. Family Doctor's name and phone # _____
2. When was your last physical exam? _____

Do you give me permission to consult with your physician about your healthcare if necessary? Yes No

3. Are you taking any medications? Yes No
If yes, what and why? _____

4. Are you currently experiencing any medical problems? _____
If yes, please explain _____

5. Have you ever been hospitalized for an emotional or mental illness? _____
If yes, please explain _____

6. How often do you use alcohol or drugs? not at all less than once per week
 more than once per week at least once per day

7. Has your use of alcohol or drugs impaired any of the following: your work functioning, relationships, finances, health, other? Please explain:

Emotional History:

1. Have you been to a counselor before? _____
2. If yes, When? _____ Why? _____
3. With whom? _____
4. Were you satisfied with the counseling? _____
5. Reason for seeking counseling at this time?
6. How long have you been experiencing this difficulty? _____
7. What kinds of things have you done in the past to deal with problems?

8. Have you ever considered suicide? ___Yes ___No When? _____

Spirituality:

1. Have your religious and/or spiritual experiences and training helped or hurt your ability to deal with struggles?

2. Do you affiliate with a specific denomination or faith? ___yes ___no

If yes, which one(s)? _____

Family of Origin:

1. Briefly describe the way it felt growing up in your childhood home(s). Please include the relationship between your parents and the relationship between parents and children.

2. Describe any turning points or significant events during your childhood that impacted you (i.e. divorce/remarriage, death of a loved one, a family move, an injury/illness, school relationships, accidents, trauma, abuse.....)

3. Do you have any family history of substance abuse or mental illness? Please Explain:

Present Family Issues:

1. Name and age of Significant Other _____ Years Together _____

2. Name and age of any children _____

3. How would you characterize your current home life? ___extremely stable ___generally stable
___we struggle more than others ___about average ___always struggling

Present Situation:

1. List any present behaviors you or others consider problematic.

2. Do you have any history of being sexually, physically, emotionally or verbally abused? ___Yes ___No

If yes, please explain:

3. Do you have any history of domestic violence? ___Victim ___Perpetrator

4. Do you have any history of an Eating Disorder? ___Yes ___No

Counseling Goals:

What are your counseling goals and what do you expect from counseling?