

Sharmaine D. Barnes, LMFT, CCTP, CEAP

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Adult Intake Questionnaire

Client Name: _____
(Last) (First) (Middle Initial)

Client's Birth Date: ____ / ____ / ____ Age: _____ Gender: _____

Ethnicity: _____ Preferred Language: _____

Sexual Orientation: _____

Highest Educational level completed: _____ Occupation: _____

MARITAL STATUS:

Never Married Domestic Partnership Married Separated Divorced Widowed

Do you have any children? Yes No If yes, how many? _____

Please list names/ages of any children: _____

Client's Address: _____
(Street and Number)

(City) (State) (Zip)

Home Phone: () _____ May I leave a message? Yes No

Cell/Other Phone: () _____ May I leave a message? Yes No

Emergency contact: _____
Name/Relation

Address: _____
(Street and Number)

(City) (State) (Zip)

Contact Phone: () _____ May we leave a message? Yes No

Referred by (if any): _____

FINANCIAL INFORMATION:

How do you intend to pay for treatment? (cash, check, charge, insurance) _____

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If planning to use health insurance:

Name of insurance company _____

Policy/ID number _____ Group number _____

Address: _____
(Street and Number)

_____ (City) _____ (State) _____ (Zip)

Contact Phone: () _____

Name of Insured (if other than client): _____

Policy/ID# _____ Group number _____

Insured's Birth Date: _____

Insured's Address: _____
(Street and Number)

_____ (City) _____ (State) _____ (Zip)

Insured's Phone Number: _____ Home Mobile Work

Insured's Employer: _____

Client's relationship to Insured: _____

AREAS OF CONCERN:

Current symptoms/behaviors/issues/concerns for which you are seeking treatment? _____

How long have you experienced the current symptoms/behaviors/issues/concerns and how do they impair your functioning at home, school, work, in relationships, in the community, etc.?

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What have you done to address the current symptoms/behaviors/issues/concerns?

Do you have any specific goals with regard to your treatment? What would you like to accomplish out of your time in therapy?

Do you have any particular concerns/fears with regard to treatment? _____

PSYCHOLOGICAL HISTORY:

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? Yes No

If yes, what was the focus of treatment? _____

When and for how long? _____

Name of mental health service provider: _____

Address: _____

(Street and Number)

(City)

(State)

(Zip)

Contact Phone: () _____

Have you ever been subjected to one or more psychological tests? Yes No

If yes, by whom? _____

Name of person(s) administered psychological tests: _____

Address: _____

(Street and Number)

(City)

(State)

(Zip)

Contact Phone: () _____

Have you ever been hospitalized for mental or emotional problems? Yes No

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If yes, when and for how long? _____

Why were you hospitalized? _____

Name of treating doctor, therapist, other provider: _____

Address: _____
(Street and Number)

(City)

(State)

(Zip)

Contact Phone: () _____

***Please note:** Authorization for release of confidential information will be needed so that any former mental health service providers may be contacted.

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

Have you ever attempted suicide? Yes No

If yes, when/how? _____

Describe the circumstances that led to that attempt: _____

Are you currently having any suicidal thoughts? Yes No

If yes, please describe _____

Please describe your childhood: _____

Have you ever been subjected to verbal, physical, emotional, sexual abuse? Yes No

If yes, please describe: _____

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Have you ever been a victim of a violent crime? Yes No

If yes, please describe: _____

Medical History:

Name of Primary Care Physician: _____

Address: _____

Phone: _____

Are you currently experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Yes No

If yes, please describe: _____

How would you rate your current physical health today? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Date of your last physical examination: _____

Allergies/allergic conditions: _____

Accidents/Surgeries/Hospitalizations: _____

Please list any specific health problems you are currently experiencing:

Are you currently taking any prescription medication? Yes No

Please list medication you are currently taking: _____

Medications prescribed by whom? _____

How long have you been on the medications? _____

Have you ever taken any medications for a mental or emotional condition? Yes No

If yes, when and for how long? _____

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Have you ever been diagnosed with a serious/chronic illness? Yes No

If yes, please describe: _____

Do you have any medical conditions that may affect your mental health treatment? Yes No

If yes, please describe: _____

Do you smoke? Yes No

If yes, how much? _____ For how long? _____

Do you drink alcohol? Yes No

Do you drink alcohol more than once a week? Yes No

If yes, on average, how much alcohol do you consume in a week? _____

Do you currently use/abuse any illegal/recreational/prescription drugs? Yes No

How often do you engage in illegal/recreational/prescription drug use/abuse?

Daily Weekly Monthly Infrequently Don't engage

Please list illegal/recreational/prescription drugs used/abused: _____

Have you ever used/abused any illegal/recreational/prescription drugs? Yes No

If yes, what did you use/how often did you use it/when did you last use it? _____

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

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Please list any difficulties you experience with your appetite or eating patterns:

Are you currently experiencing overwhelming sadness, grief or depression? Yes No

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias? Yes No

If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain? Yes No

If yes, please describe _____

Are you currently in a romantic relationship? Yes No

If yes, for how long? _____

On a scale of 1-10 (1 being the lowest level of satisfaction, 10 being the highest level of satisfaction), how would you rate your current relationship? _____

What significant life changes or stressful events have you experienced recently:

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (mother, father, sister, brother, grandmother, grandfather, aunt, uncle, etc.):

Alcohol/Substance Abuse: yes/no _____

Anxiety: yes/no _____

Depression: yes/no _____

Bipolar Disorder: yes/no _____

Eating Disorder: yes/no _____

Obesity: yes/no _____

Obsessive Compulsive Behavior: yes/no _____

Schizophrenia: yes/no _____

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Suicide Attempts: yes/no _____

Domestic Violence: yes/no _____

CRIMINAL HISTORY:

Have you ever been incarcerated? Yes No

If yes, please provide details: _____

Do you have any pending charges against you? Yes No

If yes, please provide details: _____

Are counseling services court ordered? Yes No

If yes, please provide details: _____

CPS HISTORY:

Have you ever been accused of child abuse or neglect? Yes No

If yes, please provide details: _____

Have you had or do you currently have an open CPS case? Yes No

If yes, please provide details: _____

Are counseling services court ordered? Yes No

If yes, please provide details: _____

EMPLOYMENT INFORMATION:

Are you currently employed? Yes No

If yes, what is your current employment situation: _____

Do you enjoy your work? Yes No

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Is there anything stressful about your current work? Yes No

Please describe: _____

SPIRITUAL BELIEFS:

Do you consider yourself to be spiritual or religious? Yes No

If yes, describe your faith or belief (i.e., Christian, Muslim, Buddhism, etc.): _____

Religious Affiliation/Denomination (i.e., Baptist, Methodist, Catholic, etc.): _____

ADDITIONAL INFORMATION:

Please describe your interests/hobbies: _____

Are you now or have you ever been involved in a lawsuit? No Yes

If yes, please describe. _____

What do you consider to be some of your strengths?

What do you consider to be some of your weakness? _____

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested:
