Individual Adult Questionnaire

Name ____ Date _____________
Address ____
City ___________________________________ State _______ Zip Code _____________
Email ___________________________________ Mobile Phone __________________________

Birthdate ______________ Age ______ Place of Employment____________________________
Status: _____Single _____ Married _____ In Partnership _____ Divorced _____ Widowed

Referred by: ____ Medical Provider ____ My Website ____ Friend/Family ____Other

____

Have you received mental health services in the past? ____ Yes ____No
(if yes, which of the following):

____Psychotherapy ____ Medication ____Outpatient Hospitalization
____Inpatient Hospitalization

Are you presently under a doctor's care for a physical or mental health condition? If so, please explain.

____
____
____

Are you presently taking any medications? If so, for what condition and please list.

____
____
____

Do you have any chronic illnesses/autoimmune diseases? If yes, please explain.

____
____
____

COUNSELING

What are your primary reasons for seeking counseling?

____
____
____
____
____

What symptoms are you currently experiencing?

____Sadness
____Depressed Mood
____Loneliness
____Lost of Interest
____Hopelessness
____Fatigue
____Anxiety
____Stress
____Panic Attacks
____Fear
____Upset
____Insomnia
____Anger
____Irritability
____Resentment
____Confusion
____Lack of Control
____Other

Do you have a history of experiencing any of the above symptoms? Please explain.

____
____

MENTAL HEALTH

Do you currently have any addictions? ____Yes ____No Check which apply.

Gambling ___________ Alcohol ____________ Drugs ___________ Food ________________
Smoking ____________ Shopping/Spending _____________________ Sex ________________
Other ____

Have you been in treatment/recovery for an addiction? ____________ Please explain.

____
____

Are you having strong feelings of loneliness?

____

Are you currently experiencing thoughts of not wanting to live? If Yes, Please say for how long.

____

In the past, have you had thoughts about not wanting to live? ___________________________

Have you engaged in self-harm behaviors, presently or in the past? Please explain.

____
____

Have you ever had an attempted suicide?____________ If so, when? _____________________

RELATIONSHIP HISTORY

If you are currently in a relationship, for how many months or years? ____________________

Have you had previous marriages, and if so how many? _________________________________

Have you had previous long-term partnerships/relationships? If so how long was your most recent? ____

Do you have children? ______ If yes, how many, their names, ages and location.
____
____

Do you have step-children? ______ If yes, how many, their names, ages and location.
____

Do you have grandchildren? ______ If yes, how many, their names, ages and location.
____
____

Are there other people living in your home? If yes, who? _________________________________

Do you have any pets? ______________ Their names? ____________________________________
____

Have you ever been in an abusive relationship, emotionally, mentally, physically or sexually? Please explain. ____
____
____

CHILDHOOD/FAMILY HISTORY

Were you considered a physically "healthy" child?
____
____

Were you diagnosed with any medical conditions, have any surgeries or major injuries? If yes, please explain. ____
____

Did you have any school, academic or social problems, or major successes? _________________
Please explain. ____
____

Do you feel you had a happy childhood? Please explain. ___________________________________
____
____

As a child did you have any traumatic experiences? This includes physical, mental, emotional or situational traumas ________________ If yes, please explain.
____
____
____
____

Are you adopted? ____________ Is there anything you want to share about your adoption?
____
____

Were your parents married? __________ How Long? ___________ Still married? _____________

Are you a child of divorce? If yes, the age you were when your parents divorced. Is there anything you want to share about this? ____
____
____

Do you believe your parents had a happy marriage? ________________ Can you say more about their relationship? ____
____
____

Who were you closest to growing up, mom or dad, or a step parent?
____

Do you have siblings? ________ How many? _________ If yes, which siblings were you close to?
____
____

Which siblings did you have a more challenging or difficult relationship?
____

Do you currently have any concerns about your siblings? _________ Please explain. ___________
____
____

Is there anything else you think is important for me to know about your childhood?
____
____
____
____

HAPPINESS/STRENGTHS

How happy are you now in your life?

____

Very happy | Moderately happy | Unhappy

When were you the happiest in your life?

____

What brings you joy?

____

____

Do you have any hobbies or interests? Please share. ___________________________________

____

What do you believe are your strengths as a person? ___________________________________

____

____

Do you have a good network of friends? _______ A satisfying social life? _________________

Is there anything else you would you like me to know about you or your current situation?

____

____

____

____

In case of an emergency, who is your contact person? Phone number?

____

I understand that Suzanne Nixon, EdD, LPC, LMFT is a licensed counselor & marriage & family therapist, and not a psychologist, psychiatrist or medical doctor. Please initial_________

____

Printed Name

____ Date _____________

Signature

Integrative Counseling & Relationship Therapy, Inc.
Dr. Suzanne Nixon
19415 Deerfield Avenue Suite 307
Lansdowne, VA 20176
703.729.0505