

Integrative Counseling & Relationship Therapy, Inc.

Individual Adult Questionnaire

Name _____ Date _____

Address _____ Zip Code _____

City _____ State _____ Social Security # _____

Email _____ Mobile Phone _____

Birthdate _____ Age _____ Place of Employment _____

Status: _____ Single _____ Married _____ In Partnership _____ Divorced _____ Widowed

Duration of Current Relationship _____ Previous Marriages? _____

Do you have children? _____ If yes, how many, their ages and where do they live

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

Do you have any pets? _____ Their names? _____

Are you presently under a doctor's care? If so, for what reason? _____

Are you presently taking any medications? If so, for what condition? _____

Who referred you? And may I thank them? _____

What is your reason for seeking counseling? How can I help you?

What symptoms are you currently experiencing?

<input type="checkbox"/> Unhappiness	<input type="checkbox"/> Feelings of depression	<input type="checkbox"/> Sadness
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Fear/Phobic	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Resentment	<input type="checkbox"/> Anger	<input type="checkbox"/> Loneliness
<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Stress

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

Have you ever harmed yourself or had an attempted suicide? _____
Please explain any of the above if you answered yes. _____

Have you ever been hospitalized for psychiatric reasons? _____

Are you currently, or have you ever been in an abusive relationship? _____
Please explain. _____

Do you currently have any addictions? _____ Check all that apply.

Gambling _____ Alcohol _____ Drugs _____ Food _____

Smoking _____ Shopping/Spending _____ Sex _____

Other _____

Have you been in recovery for an addiction? _____ Please explain. _____

Have you ever been in counseling before? _____ Helpful? _____

Past History

Were you a physically "healthy" child?

Did you have any school, academic or social problems? _____
Please explain. _____

Do you feel you had a happy childhood? Please explain. _____

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

Were your parents married? _____ How Long? _____ Divorced? _____
If divorced, what age were you at the time of their divorce? _____

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?

With which siblings did you have a more challenging or difficult relationship?

Do you currently have any concerns about your siblings? _____ Please explain. _____

As a child did you have any traumatic experiences? _____ If yes, please explain.

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

Happiness

How happy are you now in your life?

Very happy

Moderately happy

Unhappy

When were you the happiest in your life?

What would make you happier right now?

Is there anything else about your current situation/life that you think is important for me to
know?

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

Please note that I do not participate with insurance companies. I am a fee for service therapist. If you have a PPO, I recommend you contact your insurance company and ask how much of the counseling fee is reimbursed. Please initial. _____

I understand that Suzanne Nixon, EdD, LPC, LMFT is a professional counselor and marriage and family therapist, and is considered a mental health provider. She is not a medical doctor and does not prescribe medication. Kindly sign.

_____ Date _____