Intake Questionnaire – Adult Personal History

Counseling & Assessment Clinic (CAC)
Texas A&M University, MS 4225
College Station, TX 77843-4225

A. Identification

Today's Date: ____/ ______/ _____

Your Name: ____

Date of Birth: ____/ ______/ _______ Age: _____________ Ethnicity: ____________________

Home Street Address: ____

City: __________________________________ State: _________________ Zip: _____________

Home/evening phone: ____
With whom are you now living? ____
Marital Status (Circle): Single Married Separated Divorced Widowed Remarried

B. Referral: By whom were you referred to us? ______________________________________

C. Why have you come to the Counseling & Assessment Clinic today?

____
____
____
____
____
____

D. Your current employer: ____
Address: ____
Workplace: _______________________________

E. Your education and training

Dates From:	To:	School	Special Classes	Adjustment to school	Did you graduate?
______	_______	__________________	_________________	___________	__________
______	_______	__________________	_________________	___________	__________
______	_______	__________________	_________________	___________	__________
______	_______	__________________	_________________	___________	__________

Were you ever in special education? (Circle) Yes No

If you are a student, what is your present academic classification? (Circle)
Freshman Sophomore Junior Senior Graduate Student Other: _________________
Major: ________________________________
Are you on academic probation? (Circle) Yes No
Do you currently receive assistance through the Office for Disability Services? (Circle) Yes No

F. Employment and military experiences

Date From:	Date To:	Name of employer or military	Job title or duties	Reason for leaving
______	______	______________________	______________________	______________________
______	______	______________________	______________________	______________________
______	______	______________________	______________________	______________________
______	______	______________________	______________________	______________________

G. Family - of origin - history

Relative	Name	Current age (or age of death)	Illnesses (or cause of death, if deceased)	Education & Occupation	Psychiatric or Learning Problems
Father	__________________	__________	__________________	___________	____________
Mother	__________________	__________	__________________	___________	____________
Stepparents	__________________	__________	__________________	___________	____________
Grandparents	__________________	__________	__________________	___________	____________
	__________________	__________	__________________	___________	____________
Uncles / Aunts	__________________	__________	__________________	___________	____________
Brothers	__________________	__________	__________________	___________	____________
	__________________	__________	__________________	___________	____________
Sisters	__________________	__________	__________________	___________	____________
	__________________	__________	__________________	___________	____________

H. Marital history

Spouse's name	Your age when divorced/widowed	Is spouse remarried?
First ________________________________	________________________	_______________
Second ______________________________	________________________	_______________
Third ________________________________	________________________	_______________

I. Children

Name	Age	Grade	School
______________________	_______________	__________________	______________________
______________________	_______________	__________________	______________________
______________________	_______________	__________________	______________________
______________________	_______________	__________________	______________________
______________________	_______________	__________________	______________________

J. Previous Treatment

1. Have you ever received psychological, psychiatric or counseling services before? (Circle) Yes No

If yes, please indicate:

When?	From whom?	For what?	With what results?
____________	______________________	_______________	___________________________
____________	______________________	_______________	___________________________
____________	______________________	_______________	___________________________

2. Have you ever taken medication for psychiatric or emotional problems? (Circle) Yes No
If yes, please indicate:

When ?	From whom?	Which medications	For What	With what results
___________	__________________	__________________	___________	_______________
___________	__________________	__________________	___________	_______________

K. Substance Use (Circle one)

1. How much beer, wine, or hard liquor do you consume each week, on the average?____________

2. Have you ever felt the need to cut down on your drinking? ☐ No ☐ Yes
3. Have you ever felt annoyed by criticism of your drinking? ☐ No ☐ Yes
4. Have you ever felt guilty about your drinking? ☐ No ☐ Yes
5. Have your ever taken a morning "eye- opener"? ☐ No ☐ Yes
6. How much tobacco do you smoke or chew each week? ________________________________
7. Which drugs (not medications prescribed for you) have you used in the last 10 years?_______

____

____

L. Legal History

1. Are you presently in a legal dispute with another party that is related to your reason for seeking counseling? ____

____

____

2. Are there any other legal involvement I should know about? ____________________________

____

____

M. Medical History:

Do you have any significant medical problems?

Explain:____

____

____

Have you ever sustained a head injury? (circle) Yes No

N. Concerns:

What concern brought you to the clinic? Please read this checklist and check ONCE the items of concern to you. Please check TWICE those items which are of most concern to you and which you would like to discuss with counselors.

_____ Relationships with parents
_____ School grades
_____ Work
_____ Relationship with Spouse
_____ Eating problems
_____ Feelings of depression
_____ Social activities/involvement
_____ Headaches
_____ Self - Confidence
_____ Financial Stress
_____ Sleep problems
_____ Loneliness
_____ Relationship with girl/boyfriend
_____ Career and vocational issues
_____ Test anxiety
_____ Stress
_____ Dizziness/ Fainting spells
_____ Relationship with children
_____ Anger
_____ Friendships
_____ Sexual Matters
_____ Being assertive
_____ Suicidal thoughts
_____ Stomach problems
_____ Drug use
_____ Other ___________________

This is a strictly confidential patient record. Redisclosure or transfer is expressly prohibited by law.