Brighter Hope
Wellness Center

6100 Daylong Lane., Suite 103
Clarksville, Maryland 21029
Phone: (410) 531-8100
Fax: (410) 531-8900

ADULT INTAKE QUESTIONNAIRE

Date:_____

PATIENT & FAMILY INFORMATION

Client's Full Name:_____

Preferred Name/Nickname:_____ Birthdate:_____

Gender:_____ Race/Ethnicity:_____

Home Address:_____

_____

Cell Phone:_____ Home Phone:_____

Email:_____

Marital status: ❑ Married ❑ Separated ❑ Divorced ❑ Never married ❑ In a relationship

❑ Other: _____

EDUCATIONAL & WORK HISTORY

Highest level of education: ❑ High School ❑ College ❑ Graduate ❑ Other: _____

Occupation:_____

Employer:_____

Employer's Address:_____

_____

PHYSICAL HEALTH **Current height:**_____ **Current weight:**_____

Primary Care Physician:_____

Address:_____

_____

Referred by:_____

List of symptoms:

❑ Allergies ❑ Asthma ❑ Cancer ❑ Colic

❑ Cystic fibrosis ❑ Ear infections ❑ Eye problems ❑ GERD

❑ GI issues ❑ Head injury ❑ Hernia ❑ High fever

❑ Headaches/Migraines ❑ Loss of consciousness ❑ Seizures ❑ Orthopedic problems

❑ Urinary Tract Infections ❑ Other:_____

Use this space to further explain any of the above:_____

_____

Medications/Supplements/Vitamins

Name	Dosage	Person prescribing (if applicable)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Hospitalizations

Name of Hospital	Reason for Hospitalization	Dates of Stay
_____	_____	_____
_____	_____	_____
_____	_____	_____

MENTAL/BEHAVIORAL HEALTH

Family History (if known)

1. Family of Biological Parent (be sure to specify which one):_____

_____

2. Family of Biological Parent (be sure to specify which one):_____

_____

Household Stressors

❑ Financial ❑ Health ❑ Legal ❑ Abuse/Neglect

❑ Other:_____

Use this space to further explain any of the above:_____

_____

Prior mental health services

Name of Clinician	Reason for Services	Dates Seen
_____	_____	_____
_____	_____	_____
_____	_____	_____

What problems are you experiencing? What are your reasons for pursuing services at this time?

_____

_____

_____

_____

_____

_____

_____

_____

_____

What are your goals for therapy?

_____

_____

Current symptoms

❑ Alcohol/substance use	❑ Aggression	❑ Abuse	❑ Angry
❑ Anxiety	❑ Attention problems	❑ Arguing	❑ Cruel to animals
❑ Cheating/Infidelity	❑ Developmental delay	❑ Stubborn	❑ Eating problems
❑ Energy (hyperactive)	❑ Low energy	❑ Fearful	❑ Fighting
❑ Hair pulling	❑ Immature	❑ Impulsive	❑ Irritable
❑ Learning problems	❑ Lying	❑ Moody	❑ Nail biting
❑ Nightmares	❑ Runs away	❑ Sad	❑ Self-harm
❑ Shy	❑ Risky behavior	❑ Rituals	❑ Social problems
❑ Suicidal	❑ Swearing/cursing	❑ School refusal	❑ Anger outburst

❑ Other:_____

When did these problems begin:_____

SOCIAL/RECREATIONAL

Indicate how much and how often you use these substances (if applicable):

Alcohol:_____ Caffeine:_____

Drugs:_____ Tobacco:_____

List any other persons who live in the same household as you:

Name	Relationship & Age	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of Spouse/Partner/Significant Other:_____

Home Address:_____

_____

Cell Phone:_____ Home Phone:_____

Email:_____ Occupation:_____

Describe your support systems:_____

_____

_____

INTERESTS/BELIEFS/PERSONALITY

Religious, spiritual, or cultural/ethnic beliefs:_____

_____

Interests:_____

_____

Activities:_____

_____

Strengths:_____

_____

ADDITIONAL COMMENTS

Use this space to write any additional comments or concerns that would be helpful to know.