GRANGER
MEDICAL CLINIC

Adult Intake Questionnaire

Identification Information

Name: _____

DOB: _____ Age: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Choose One: ☐ Work ☐ Home ☐ Cell

Do we have permission to leave a message for you at the above number? ☐ Yes ☐ No

Marital Status: _____

Emergency Contact Name and Phone #: _____

Employment and Education

Occupation: _____

Employer: _____

Average hours worked per week: _____

Do you enjoy your occupation? _____

What is your highest level of education? ☐ Highschool ☐ Some College ☐ College Degree
☐ Graduate School ☐ Other: _____

If you received a college degree, what was your degree in? _____

If you are currently a student, what are you studying? _____

Religion/Spirituality

How would you describe you spiritual or religious beliefs? _____

_____

_____

_____

Family Information

Family of Origin: Please provide names and ages of parents, siblings, step-siblings, and other significant family members.

Name	Age	Relationship	City, State

Children: Please list all of your children including biological, step children, adopted, or foster.

Name	Age	Relationship	City, State	Lives at Home? Y/N

Previous Treatment

Have you received counseling, psychological, or psychiatric services before? ☐ Yes ☐ No

If yes, please provide the following information:

When	Name of Treating Professional	Reason for Treatment	Outcome

Medical Information

Name of Primary Care Provider: _____

Have you ever taken medication for psychiatric and/or emotional problems? ☐ Yes ☐ No

If yes, please provide some additional information:

When?	Prescribing Provider	Name of Medication	For what condition?	Results

Please list any major medical concerns or chronic illnesses, disabilities, or conditions that you have been diagnosed with:

_____

_____

_____

_____

Please list the medications that you are currently taking:

_____

_____

_____

_____

_____

Are you currently taking your medications as they have been prescribed? ☐ Yes ☐ No

If not, please briefly explain: _____

Other

Please briefly share your reason for seeking therapy at this time:

_____

_____

_____

What goals do you hope to accomplish during therapy?

_____

_____

Is there anything else that you think would be helpful for your therapist to know about you and/or your family?

_____

_____

_____