Solution-Focused Adult Intake Questionnaire

Demographic Information: Today's date:___________________

Name: ____ DOB:__________ Age____________
Address:____
Phone: home:____________________________ Cell_________________________________
Referral source:____

Primary care doctor: Name: ____
Phone:____________________________Fax:____
Address:____

Occupation:____
Marital status:__________________Eduation______________________________________

How can I be most helpful for you?/ What are your best hopes for treatment that would tell you it is worthwhile

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What will different for you that would tell that our time was successful?

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What would tell you that you no longer are in need of treatment and have the necessary skills to graduate from this treatment episode?

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____

What have you tried to do to help with these concerns?

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What are some things you enjoy and/or good at?

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____
____
____

Who are the people who have been most helpful for you?/ What have they done that has been most helpful for you?

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____
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Who are the most important relationships in your life?/ What do you most appreciate about them?/ What do they most appreciate about you?

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Whose idea was it for you to come today?/ Who was concerned that thought you coming here would be helpful for you?

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MEDICATION HISTORY: What do you know about your medications?

YES NO

Medication	Dosage	Start date	Stop date	Effects/side-effects (If yes, how have you managed them?)	How helpful have they been from 1-10(10 the most helpful)

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Have you received any prior treatment or evaluations? Yes/No

What do you know about these prior evaluations?

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____
____

What treatments have been most helpful for you?

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____
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YES NO

Provider/Type of treatment/Intervention	How helpful (1-10) 10 being most helpful	Dates of treatment

Medical history:
Are there any medical issues that you are currently being treated for: YES NO

____

What do you know about your medical conditions/ medications?

____
____

What has helped you manage your medical conditions/medications?

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____
____

Allergies to medication: NO YES:______________________ Reaction_________________
Prior surgeries: NO_________________________YES:____________________

Health History:

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Do you have any of the following	No	Yes	If yes, how well have you managed from 1-10 (10 the best)
Allergies			
Asthma			
Attention deficit disorder			
Chronic ear infections			
Lead poisoning			
Speech or language problems			
Problems with immune system			
Cancer			
Chest pain			
High blood pressure			
Shortness of breath at night			
Shortness of breath on exertion/exercise			
Irregular heart rate/ abnormal EKG			
Congenital heart problems/Heart murmur			
Fainting			
Heart attack			
Stroke			
Visual impairment/cataracts Glaucoma/glasses			
Difficulty hearing			
Reduced smell or taste			
Diabetes			
Thyroid problems			
Heart burn/ulcers			
Diarrhea/constipation/ Rectal bleeding/encopresis			
Urine: infections, burning, incontinence, enuresis			
Kidney problems			
Sexual: Pain, inhibition, sexually transmitted diseases			
# Pregnancies, live births, living children			
Irregular periods			
Anemia			
Clotting problems			
Liver disease: Hepatitis, jaundice			
Broken bones			
Back problems/pain medications			
Arthritis			
Weakness/paralysis			
Head injury			
Black outs			

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Seizure/ epilepsy			
Severe headaches			
Involuntary movements/tremor/tics			
Sleep disturbance: insomnia Apnea/increased sleep			

Substance History: If none or not currently, how did you decide to stop?

If yes, have they been helpful? How have they been helpful for you?

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____

Have you experienced cravings to use: Yes No
If Yes, how well have you been managing your cravings from 1-10 (10 being the best)?

____

____

What is your longest period of sobriety?______________________________

How confident are you in your skills to remain sober from 1-10?______________

How much do you think you need to remain sober from 1-10?________________

What do you know has helped you maintain your sobriety? What else?

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____

Who has helped you remain sober? Who else?/ How have they helped you?

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Have you had periods of relapse? Yes No

If yes: What do you know has helped you get back on track following a relapse?
What else has helped you get back on track?

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____

Substance	None	Amount	Frequency	1st use	Last Use
Tobacco					
Alcohol					

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Marijuana					
Prescription pills					
Cocaine					
Crack					
Inhalants					
Heroin					
Other					

Have you had to cope with abuse, loss, domestic violence, natural disaster, family trauma, or other traumatic events? If so, how have you coped?

____

____

Is Faith important for you? If so, how is it helpful:__________________________

Guns in the home: Y N: If yes, are they kept locked and in a safe: Y N

What do you know about guns and risks in the home?

____

Biologic Family, Medical and Psychiatric history

Has anyone in your family had to cope with the following conditions? (if adopted, indicate information on any known biological relatives and indicate information on adoptive family members on lines below

Illness	Yes	No	Who	What was most helpful for them?
Depression				
Manic Depression/Bipolar				
Anxiety or panic attacks				
Obsessive compulsive disorder				
Psychiatric hospitalization				
Schizophrenia				

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Suicide (attempt or completion)				
Reading problems or Dyslexia				
School problems				
Mental retardation				
Autism/Asperger's disorder				
Speech or language problems				
Attention problems/ADHD				
Behavior problems as a child or teen				
Alcohol problems				
Drug problems Trouble with the Law				
Seizures				
Birth defects				
Tics/Tourettes syndrome				
Thyroid disorder				
Heart problems before the age of 50				
Any Genetic disorder				
Physical or sexual abuse				
Diabetes				
Clotting problems				
Cancer				
Sleep disturbance				
Liver disease: Hepatitis				
Infectious diseases				
Asthma/respiratory problems				
Problems with immune system				
Other problems of concern				

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Is there any other additional information that you think would be helpful for me to know?

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