

Dawn Stremel, MA, LMFT

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ADULT QUESTIONNAIRE

Today's date: _____

Name: _____ Gender: _____ Age: _____ Birthdate: _____
Address: _____ City: _____ Zip Code: _____
Home Phone Number: _____ Cell Number: _____
Work Number: _____ Ok to leave messages at these numbers? _____
Ok to receive texts on Cell Number? _____
Email _____ Ok to leave messages on email? _____

WORK

Occupation/Place of Employment: _____
Insurance (Name, Group #, Individual #): _____

Responsible party, if other than yourself: _____
Relationship to you: _____

RELATIONSHIPS

____ Single ____ Married; Married how long? _____
____ Coupled, not married; Coupled how long? _____
____ Separated; how long? _____
____ Divorced; how long? _____
____ Widowed; how long? _____

Previous marriages/briefly explain: _____

Current spouse or partner: _____ Age: _____ Birthdate: _____
Employer: _____ Insurance: _____

Children: _____ Age: _____ Grade/School: _____
_____ Age: _____ Grade/School: _____
_____ Age: _____ Grade/School: _____
_____ Age: _____ Grade/School: _____

THERAPY

1. Please describe any prior therapy you have received, including name(s) of therapist, nature of problem, dates of attendance:

2. Please describe the present problem(s):

3. What are your goals for seeking treatment at this time?

HEALTH and WELLNESS

1. Please describe any health problems/hospitalizations:

Do you smoke: _____ If so, how much a day/week? _____

Do you use recreational drugs: _____ If so, what kind and how often do you use?

Do you use alcohol? _____ If so, how much a day/week?

Ever attended outpatient chemical dependency treatment? _____ If so, when? _____

Ever attended inpatient chemical dependency treatment? _____ If so, when? _____

Any pending legal issues? _____

Sleep issues? _____ Please describe: _____

Appetite/weight issues? _____ Please describe: _____

Current physician (name and phone): _____

2. List all current **medications**, including **dosage**, when you take, how long you have been taking it, and what **condition** the medication was prescribed to treat:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Is there anything else that would be helpful for me to know?