PATHWAYS
COUNSELING CENTER

11121 W. Oklahoma Ave
West Allis, WI, 53227
P (262) 641-9790
F (262) 641-9791

Adult Pre-Treatment Questionnaire

To better assess if we can meet your needs, please fill out as completely as you can and bring with you to your first therapy appointment. Use additional sheets of paper as needed. The information you provide is confidential and protected by law.

Date Completed: _____

Name: _____ **Spouse/Partner's Name:** _____

1. Gender: I identify as… Male ___ Female ___ Transgender ___ **2.** Age: ____ Years

3. Ethnicity: _____ **4.** Religion: _____

5. Partner/Marital Status: _____. Please describe more about your current and past relationships and the quality of those relationships.

___ Never Married _____
___ Living Together
___ Married _____
___ Separated
___ Divorced _____
___ Widowed

6. Current Employment

___ Full-time ___ Student
___ Part-time ___ Disabled
___ Homemaker ___ Retired
___ Unemployed
___ Laid off

7. Education

___ Grade 8 or less
___ Some high school
___ Some college
___ College graduate
___ College beyond BS/BA

Please describe more about your current and past schooling/employment. Are you satisfied with your school/work?

_____

_____

8. Who lives in your home?

Name	Gender	Age (list)	Relationship?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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9. Are you currently under a physician's care? (circle one) YES NO Date of last physical exam: ______________

List **current medical conditions**, medications, dosage, and physician's name (Add on the back if needed):

Condition | Medication & Dosage | Physician

____

____

____

____

What kind of psychiatric meds have you taken in the **past**? What kind of response did you see?

____

____

Does your biological family have significant medical or psychiatric illnesses? (Include substance abuse, suicide, etc.)

____

____

What kind of sleeping pattern do you currently have (e.g. bedtime, wake time, restful, restless)?

____

What kind of eating patterns or food issues do you currently identify as having?

____

10. Have you received prior counseling or related services? (circle one) YES NO (Add on the back if needed.)

Name of therapist: ______________________ Where: ______________________
Length of treatment: ________ months/years How long ago? ________ months/years ago
Problem(s) treated: ______________________
Outcome: (circle one) 1 2 3 4 5 6 7 8 9 10
Much worse Stayed the same Much better

Name of therapist: ______________________ Where: ______________________
Length of treatment: ________ months/years How long ago? ________ months/years ago
Problem(s) treated: ______________________
Outcome: (circle one) 1 2 3 4 5 6 7 8 9 10
Much worse Stayed the same Much better

Name of therapist: ______________________ Where: ______________________
Length of treatment: ________ months/years How long ago? ________ months/years ago
Problem(s) treated: ______________________
Outcome: (circle one) 1 2 3 4 5 6 7 8 9 10
Much worse Stayed the same Much better

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11. Do you have past or current experiences of abuse of any kind, including physical, emotional, verbal, or sexual? Please share below or with your therapist.

_____

_____

_____

_____

12. Please describe **current** substance use/abuse in the chart below. **Please mark N/A if not applicable.**

	Typical Frequency of Use in Past 6 Months					**Time of Last Use**		
	Daily	1-6 Times A Week	Weekend Use Only	Few Times/ Month	Once a Month or Less	Within Past Week	Within Past Month	Over 1 Month Ago
Alcohol								
Marijuana								
Cocaine (Powder, Crack)								
Amphetamines (Crystal Meth)								
Sedatives								
Minor Tranquilizers (Valium)								
Hallucinogens								
Barbiturates								
Heroin								
Other Opiates/Narcotics								
Inhalants								
Nicotine (Cigs, Vape)								
Caffeine								
Other: _____								

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13. Please describe any current or past legal trouble (criminal and family) you are in or have had:

_____

_____

14. Please check up to 3 of the **most important** reasons listed below which led you to seek treatment:

___ Depression or anxiety
___ Worry about drinking or drug use
___ Communication problems
___ Desire to improve sexual relations
___ Parent/child conflict
___ Sexual orientation questions
___ Problematic or too much anger
___ Social isolation or other social challenges
___ Trouble controlling impulses
___ Abuse (physical/sexual/emotional/verbal)
___ Trauma other than abuse (natural disaster, accident, crime witness, etc.)
___ Thinking of harming self or others
___ Learning/memory problems
___ Difficulty with loss or death
___ Want relationship to be better
___ Divorce counseling
___ Individual counseling
___ Pre-marital counseling
___ Family counseling
___ Couples counseling
___ Partner/family member wanted me to come
___ Gender identity/transition
___ Other: _____

15. Regarding the **most important** reason that brings you here, please rate the following:

Reason 1: _____

How often does issue happen?
___ Happens rarely
___ Happens 1-2 times a week
___ Happens 3-5 times a week
___ Happens daily
___ Happens several times a day

How does it affect your functioning?
___ I can do all the things I need and want to do
___ I struggle a bit but am able t do all I need and want to do
___ I can only do some of the things I need and want to do
___ I can barely do the things I need to do
___ I am unable to work or care for myself

Reason 2: _____

How often does issue happen?
___ Happens rarely
___ Happens 1-2 times a week
___ Happens 3-5 times a week
___ Happens daily
___ Happens several times a day

How does it affect your functioning?
___ I can do all the things I need and want to do
___ I struggle a bit but am able t do all I need and want to do
___ I can only do some of the things I need and want to do
___ I can barely do the things I need to do
___ I am unable to work or care for myself

Reason 3: _____

How often does issue happen?
___ Happens rarely
___ Happens 1-2 times a week
___ Happens 3-5 times a week
___ Happens daily
___ Happens several times a day

How does it affect your functioning?
___ I can do all the things I need and want to do
___ I struggle a bit but am able t do all I need and want to do
___ I can only do some of the things I need and want to do
___ I can barely do the things I need to do
___ I am unable to work or care for myself

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16. Who referred you to Pathways Counseling Center?

_____

17. What questions do you hope will be answered through therapy?

_____

_____

_____

18. Please describe some of your personal strengths you possess:

_____

_____

19. Please describe some of your personal challenges or obstacles in your way:

_____

_____

20. How will you know that things are getting better?

_____

_____

21. Is there anything else you want the therapist or counselor to know before your first session?

_____

_____

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22. To get a better understanding of your symptoms, please complete the table below and bring to your first therapy appointment.

Over the last 2 weeks, how often have you been bothered by the following symptoms?

	Never	Several days	More than half the days	Daily
Sadness, hopelessness, feeling down				
Poor appetite or overeating; weight loss or gain				
Loss of interest or pleasure in doing things				
Fatigue or loss of energy				
Feeling bad about yourself – that you are a failure or have let yourself or your family down				
Trouble concentrating, making simple decisions				
Thoughts of death or suicide				
Trouble falling or staying asleep, restless and unsatisfying sleep, or sleeping too much				
	Never	Several days	More than half the days	Daily
Restlessness, feeling keyed-up, or on edge				
Being easily tired				
Problems concentrating or mind goes blank				
Irritability				
Muscle tension				
	Never	Several days	More than half the days	Daily
An intense and persistent fear of a social situation in which people might judge you				
Fear that you might be humiliated by your actions				
Fear that people will notice that you are blushing, sweating, trembling, or showing other signs of anxiety				
Knowing that your fear is excessive or unreasonable				

Please provide any other information that you feel is important for the therapist to know:

_____

_____

_____

_____

Signature: _____ Date: _____