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**ADULT CLIENT QUESTIONNAIRE**

Date \_\_\_\_\_

Full Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Safe to Leave a Message? Y/N

Work Phone \_\_\_\_\_ Safe to Leave a Message? Y/N

Cell Phone \_\_\_\_\_ Safe to Leave a Message? Y/N

Referred by: \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Subscriber ID# \_\_\_\_\_

Marital Status \_\_\_\_\_ Health Status \_\_\_\_\_

Current Medications \_\_\_\_\_

General Medical History \_\_\_\_\_

\_\_\_\_\_  
(use back of page if needed)

Allergies/Allergic Reactions \_\_\_\_\_

Occupation \_\_\_\_\_ Educational Level \_\_\_\_\_

List all other persons living in the home:

Name	Age	Relationship to Client	Present Health Status

Will you be financially responsible for these services? Y/N If no, please complete below:

**RESPONSIBLE PARTY INFORMATION:**

Name: \_\_\_\_\_ Relationship to Client \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other \_\_\_\_\_

If you share custody of your children, please describe the current arrangement, including visitation:

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Have you ever been under the care of another mental health provider? [ ] Yes [ ] No; If "Yes," please explain:

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Describe your daily alcohol consumption: \_\_\_\_\_



Describe any substance use for any members of your household: \_\_\_\_\_

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Are there ever any times that you feel unsafe in your home? \_\_\_\_\_

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Are you involved in any ongoing legal matters? If yes, please explain: \_\_\_\_\_

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Please provide a brief description of how we can help you.

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