

# Genesis Counseling Services, Ltd.

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www.genescounselingservices.com

## Adult Questionnaire

**Client Name:** \_\_\_\_\_

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

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

### Marital/Family Status:

Single  Married  Divorced  Other: \_\_\_\_\_

Name of spouse/partner: \_\_\_\_\_

Names and ages of children: \_\_\_\_\_

\_\_\_\_\_

### Preferred means of contact:

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

**Employed:**  Yes  No

Name of employer: \_\_\_\_\_

Length of employment: \_\_\_\_\_

**Student:**  Yes  No

Name of school: \_\_\_\_\_

**Is client their own Legal Representative/Guardian?**

**Does client have a Foster Parent/Caretaker?**

**Does client have a Payee?**

**Does client have a Primary Physician?**  Yes  No

If yes, please provide name, clinic & phone: \_\_\_\_\_

**Does client have a Social Worker?**  Yes  No

If yes, please provide name & phone: \_\_\_\_\_

**Has client taken medications in the past 12 months?**  Yes  No

If yes, please list: \_\_\_\_\_

**Has client received mental health treatment in the past 12 months?**  Yes  No

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_  
Client/Representative Signature / Date

**Primary Insurance:** \_\_\_\_\_

**(Please present card to office staff)**

Cardholder's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

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

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

**(Please present card to office staff)**

Cardholder's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

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

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Yes  No If **no**, see back

Yes  No If **yes**, see back

Yes  No If **yes**, see back

\_\_\_\_\_  
Office Staff Signature / Date

**Legal Representative/Guardian:**

Must sign intake paperwork

Name: \_\_\_\_\_

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

\_\_\_\_\_

Phone Number: \_\_\_\_\_

**Foster Parent/ Caretaker:**

Will receive reminder phone calls

Name: \_\_\_\_\_

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

\_\_\_\_\_

Phone Number: \_\_\_\_\_

**Payee:**

Will receive monthly statements

Name: \_\_\_\_\_

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

\_\_\_\_\_

Phone Number: \_\_\_\_\_