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Adult Questionnaire

Please complete all information on this form. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name_____Date_____

Address:_____

City:_____ State:_____ Zip Code: _____

Home Phone:_____ Cell Phone:_____

Email:_____

Emergency Contact: _____Relationship:_____ Phone: _____

Date of Birth_____Primary Care Physician_____

Primary Insurance Carrier: _____ Member Number: _____

Secondary Insurance Carrier: _____ Member Number: _____

Primary Care Physician: _____ Telephone #: _____

Do you give permission for ongoing regular updates to be provided to your primary care physician?

( ) Yes ( ) No

Current Therapist/Counselor_____ Telephone #: _____

Do you give permission for ongoing regular updates to be provided to your therapist/counselor?

( ) Yes ( ) No

What are the issue(s) for which you are seeking help?

_____

_____

_____

What are your treatment goals?

_____

_____

_____

Educational History:

Highest Grade Completed? _____ Where? _____

Did you attend college? ( ) Yes ( ) No Where? _____ Major or Field of Study? _____

What is your highest educational level or degree attained? _____

Occupational History:

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

How long in present position? _____

What is/was your occupation? _____

Where do you work? _____

Have you ever served in the military? _____ If so, what branch and when? _____

Honorable discharge ( ) Yes ( ) No Other type discharge _____

Legal History:

Have you ever been arrested? (provide details) _____

_____

Do you have any pending legal problems? (provide details) _____

_____

Relationship History and Current Family:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed How long? _____

If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____

Describe your relationship with your spouse or significant other: _____

_____

Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? ____ How long? _____

Do you have children? ( ) Yes ( ) No

If yes, list ages and gender: _____

_____

_____

_____

Describe your relationship with your children: List everyone who currently lives with you. _____

_____

_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

Symptom	Check Once for Present Twice for Major	Describe
Depressed Mood		
Unable to Enjoy Activities		
Sleep Pattern Disturbance		
Loss of Interest		
Concentration/Forgetfulness		
Change in Appetite		
Excessive Guilt		
Fatigue		
Decreased Libido		
Increased Libido		
Racing Thoughts		
Impulsivity		
Increase Risky Behavior		
Decreased Need for Sleep		
Excessive Energy		
Increased Irritability		
Crying Spells		
Excessive Worry		
Anxiety Attacks		
Avoidance		
Hallucinations		
Suspiciousness		
Other _____		

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.

If YES, please answer the following. If NO, please skip to the next section.

Do you **currently** feel that you don't want to live? ( ) Yes ( ) No

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

_____

What is your current mental health diagnosis?

_____

_____

_____

_____

Medical History:

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name	Total Daily Dosage	Estimated Start Date

Current Over-the-Counter Medications or Supplements

_____

_____

Current Medical Conditions

_____

_____

Past Medical History, Hospitalizations or Surgeries (Non-Psychiatric))

_____

_____

Family Background and Childhood History:

Where did you grow up? _____

List your siblings and their ages: _____

_____

What was your father's occupation? _____

What was your mother's occupation? _____

Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____

If your parents divorced, who did you live with?_____

Describe your father and your relationship with him: _____

_____

Describe your mother and your relationship with her: _____

_____

How old were you when you left home? _____

Has anyone in your immediate family died? Who and when? _____

_____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.

Please describe when, where and by whom: _____

_____

_____

_____

_____

Personal and Family Medical History

Are there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain:

_____

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____

_____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

	Yes	No	If Yes, Who
Bipolar Disorder			
Depression			
Anxiety			
Anger			
Suicide			
Schizophrenia			
Post-Traumatic Stress			
Alcohol Abuse			
Other Substance Abuse			
Violence			

Your History

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.

Reason	Dates	With Whom	Nature of Treatment

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where.

Reason	Dates	Where	Nature of Treatment

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? _____

If yes, where were you treated and when? _____

_____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____ The most number? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?

_____

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months? ( ) Yes ( ) No

If yes, which ones? _____

Have you ever abused prescription medication? ( ) Yes ( ) No

If yes, which ones and for how long? _____

_____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:

Do you currently smoke cigarettes? **( )** Yes **( )** No

How many packs per day on average? _____ How many years? _____

Is there anything else that you would like me to know?

_____

_____

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_____

_____ _____

Signature Date

_____ _____

Guardian Signature Date

_____ _____

Emergency Contact Telephone