Kansas City Psychiatric Group

(revision 4/27/15)

ADULT QUESTIONNAIRE

Name_____ **Date**_____
Last **First** **Middle**

Birthdate_____ **Age**_____ **Physician:**_____

Sex____ **Height:**_____ **Weight:**_____ **Referred by**_____

PRESENTING PROBLEMS:
List your difficulties or other needs we may assist you with.

_____

_____

_____

_____

PLEASE CIRCLE ANY OF THE FOLLOWING PROBLEMS WHICH PERTAIN TO YOU:

Aggression	**Food Restriction**	**Learning Problems**	**Seeing Visions**
Alcohol Use	**Guilt**	**Loneliness**	**Self Injury**
Anxiety	**Headaches**	**Mood Swings**	**Sexual Problems**
Appetite Changes	**Hearing Voices**	**Nervousness**	**Sleep Changes**
Binge Eating	**Homicidal Thoughts**	**Nightmares**	**Stomachaches**
Confusion	**Hopelessness**	**Obsessive Thoughts**	**Stress**
Daytime Napping	**Hypersexuality**	**Panic Attacks**	**Suicidal Thoughts**
Depression	**Inability to Sleep**	**Paranoia**	**Tiredness**
Dizziness	**Inattention**	**Poor Memory**	**Unhappiness**
Drug Use	**Involuntary Movement**	**Purging**	**Vivid Dreams**
Eating Problems	**Irritability**	**Racing Thoughts**	**Weight Gain**
Excessive Sleep	**Low Interest in Activities**	**Restlessness**	**Weight Loss**

PSYCHIATRIC HISTORY:
Have you ever received psychological help or counseling of any kind before? _____Yes _____No
Are you currently being treated for a psychiatric illness? ____Yes ____No
If yes, please explain:_____

_____

Please list all psychiatric or therapeutic treatment on either an outpatient or inpatient basis. Use the back of this form for additional space.

Date **Hospital or Clinician** **Reason**

_____

_____

_____

List any suicide attempts:_____

_____

Describe any traumatic events:_____

_____

_____

MEDICAL AND SURGICAL HISTORY:

Please list all surgical or medical treatment given you on either an outpatient or inpatient basis. Use the back of this form if necessary.

Date	Hospital/Doctor	Reason

Are you currently being treated for a medical illness? ___yes ___no

If yes, please explain: _____

_____

Do you have/have you had any of the following:

Overweight **High Blood Pressure** **High Cholesterol** **Thyroid Problems**

Blood Sugar Problems **Pregnancies #_____** **Live Births #_____**

List ALL MEDICATIONS you are currently taking: _____

_____

_____

_____

List all psychiatric medications you have taken in the PAST (e.g. antidepressant, anxiety medication, sleeping pills, etc.):

_____

_____

_____

Are you allergic to any medication or have other allergies? _____

_____

_____

DRUG AND ALCOHOL HISTORY:

List below all forms of alcohol, drugs and prescription drugs which you have ever used or abused. Use the back of this form for additional space.

Type (please circle)	Amount	First Use	Last Use
Alcohol			
Marijuana			
Cocaine			
Methamphetamine			
LSD/Opiates/Heroin/IV Drugs			
Other:			
Caffeine (coffee, soda, etc.)			
Nicotine (cigarettes, etc.) (packs per day)			

Have you ever received treatment for drug and/or alcohol abuse problems? ____yes ____no

If yes, describe: _____

FAMILY HISTORY:

Do you have any relatives with known or suspected psychiatric or emotional difficulties (i.e. depression, anxiety, alcohol or drug abuse, schizophrenia, learning disabilities, hyperactivity, etc?)

Mother _____

Father _____

Siblings _____

Children _____

Other _____

Has anyone related to you attempted suicide or died by suicide? _____

MARITAL HISTORY:

Marital Status: ___single ___separated ___living together ___married ___divorced ___other

Dates of marriage: From_____ To_____ # of years_____
Dates of other marriages: From_____ To_____ # of years_____
Dates of other marriages: From_____ To_____ # of years_____

Number of Children: _____ Biological _____ Stepchildren

LIVING SITUATION:

Please list people living in the home:

Name	Relationship	Age	Sex
1.			
2.			
3.			
4.			
5.			
6.			

EDUCATIONAL HISTORY:

	High School	Trade/Technical	Jr. College	College
Years Completed:				
Did you graduate?	Yes/No	Yes/No	Yes/No	Yes/No

If you dropped out before completing education, please explain: _____

_____

How well did you do with your studies? Please explain: _____

_____

EMPLOYMENT HISTORY:

Please list all employment from over the last five (5) years.

Company	Position	To	From	Reason for Leaving

MILITARY HISTORY:

Branch of Service	From	To	Rank	Type of Discharge

LEGAL HISTORY: