

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 |
|--|--------|-----------|----------|
| <u>Alcohol</u> | | | |
| <u>Marijuana</u> | | | |
| <u>Cocaine</u> | | | |
| <u>Methamphetamine</u> | | | |
| <u>LSD/Opiates/Heroin/IV Drugs</u> | | | |
| <u>Other:</u> | | | |
| Caffeine (coffee, soda, etc.) | | | |
| Nicotine (cigarettes, etc.) (<u>packs per day</u>) | | | |

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:
