Lifestyle Insight Therapy, LLC

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Adult History Questionnaire

Please provide the following information. Leave blank any question you would rather not answer, or would prefer to discuss with me. Information you provide here is confidential.

Today's Date:_____/______/_______ Client Name:________________________________

Date of Birth:_____/______/_____ Age:________ Preferred Name:____________________

Preferred Gender:_________________ Sexual Orientation:____________________

What are the primary concerns that have brought you in today?

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____

Persons living in the household (name/age/relationship):

____
____
____

History

Have you received any type of mental health services in the past (therapy, psychiatric services, etc)?

☐ No ☐ Yes If yes, previous services/practitioner/date:_____________________________

Are you currently receiving additional mental health services (therapy, psychiatric services, etc)?

☐ No ☐ Yes If yes, please describe:____

Are you currently taking prescribed medication? ☐ No ☐ Yes
If yes, please list/dose:

____
____
____

Family Mental Health History

Have you or your family members experienced any of the following:

- ☐ Alcohol/Substance Use
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ ADHD
- ☐ Suicide Attempts
- ☐ OCD
- ☐ Depression
- ☐ Eating Disorder
- ☐ Schizophrenia
- ☐ Autism Spectrum Disorder
- ☐ Obesity
- ☐ Learning Problems

If yes, please list which family member(s):

____

____

____

Current Health

Have you experienced any of the following in the past month?

- ☐ Increased/Decreased Appetite
- ☐ Fatigue
- ☐ Trouble concentrating
- ☐ Sleep Disturbance
- ☐ Suicidal thoughts
- ☐ Impulsive behavior
- ☐ Acting out/anger
- ☐ Panic Attacks
- ☐ Self-harm
- ☐ Substance Use
- ☐ Anxiety
- ☐ Body-Image concerns
- ☐ Other- Please list:____

Do you exercise? ☐ No ☐ Yes If yes, how often?__________________________

Do you drink alcohol? ☐ No ☐ Yes If yes, how many times per week?____________

Do you currently, or in the past, have you used any of the following?

- ☐ Marijuana
- ☐ Non-prescribed medication
- ☐ Cocaine
- ☐ Heroin
- ☐ Methamphetamine
- ☐ Other- Please list:______________

What do you hope to accomplish from our work together?

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