

ADULT HISTORY QUESTIONNAIRE

Please bring this completed form with you at the time of your initial appointment.

REFERRAL INFORMATION

Name _____

Birth Date _____ Age _____ Sex _____

Home Address _____

Home Phone Number (_____) _____

Work Phone Number (_____) _____

Cell Phone Number (_____) _____

Email Address _____

By whom were you referred? _____

Person we should contact in the event of an emergency:

Name _____ Relationship _____

Phone Number (_____) _____

Describe your major concerns, including duration of those concerns and any previous attempts to resolve them.

Indicate with a check mark how severe your concerns are at this point in time:

- ☐ mildly upsetting
- ☐ moderately severe
- ☐ very severe
- ☐ extremely severe
- ☐ incapacitating

Please describe below any major life stressors that have occurred to you or your family during the past year.

What goals do you have for your treatment?

List past and/or present counseling and evaluation services:

<u>Counselor</u>	<u>Dates Seen</u>	<u>Records Available?</u>

Medical Development History

Primary Care Physician: Name _____
Address _____
Phone (____) _____

Present or Chronic Illnesses:

Current Medications (indicate dosage and prescribing physician):

Past Psychiatric Medications:

<u>Medication</u>	<u>Dose</u>	<u>Response</u>	<u>Why stopped</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: _____

Please indicate with a check mark if your childhood/adolescent/young adult history includes any of the following:

- | | |
|---|--|
| ☐ birth complications | ☐ attention difficulties |
| ☐ major childhood illnesses | ☐ victim of sexual abuse |
| ☐ major childhood injuries | ☐ victim of physical abuse |
| ☐ major childhood stresses | ☐ difficult family situation |
| ☐ head injury (major or minor) | ☐ problematic childhood/adolescence |
| ☐ seizures | ☐ childhood behavior problems |
| ☐ substance or alcohol abuse | ☐ childhood legal problems |
| ☐ childhood anxiety | ☐ learning disabilities |
| ☐ childhood depression | ☐ parental separation/divorce |
| ☐ allergies | ☐ adoption |

Please provide details concerning checked items: _____

Educational/Occupational Information

EDUCATION

Highest grade completed in school, including degrees earned (indicate subject major).

Describe your academic strengths.

Describe any academic difficulties.

Compared to other students you went to school with as a child, how would you rate your overall intelligence level?

____ below average ____ average ____ above average ____ gifted

OCCUPATION

Describe your current employment position _____

Number of years _____

List other positions you have held:

Type of Job

Years

Are you satisfied with your present work? _____

If not, in what ways are you dissatisfied? _____

INTERESTS

Describe your present interests or hobbies.

Present Areas of Concern

All people encounter difficulties from time to time. Please indicate with a check mark those areas of concern which you believe pose particular challenges for you at this time.

TENSIONS/WORRIES

- ☐ fearful
- ☐ panicky
- ☐ feeling keyed up or on edge
- ☐ easily fatigued
- ☐ difficulty concentrating
- ☐ repetitive worries
- ☐ repetitive actions to prevent stress
- ☐ fear of dying
- ☐ irritable
- ☐ frequent stomachaches
- ☐ frequent headaches
- ☐ specific fears (indicate _____)

EMOTIONS

- ☐ sadness or tearfulness
- ☐ low self-esteem
- ☐ lack of enjoyment/interest
- ☐ low energy
- ☐ feelings of worthlessness
- ☐ feelings of guilt
- ☐ grieving
- ☐ feeling hopeless
- ☐ over-excited
- ☐ under-excited
- ☐ angry
- ☐ slow-moving/under-active
- ☐ moody
- ☐ difficulty controlling temper
- ☐ thoughts of hurting self
- ☐ thoughts of doing something uncontrolled

OTHER

- ☐ career indecision
- ☐ identity issues
- ☐ eating problems
- ☐ weight loss or gain
- ☐ substance abuse
- ☐ excessive use of alcohol
- ☐ unusual thoughts or feelings
- ☐ legal problems

ATTENTION/LEARNING

- ☐ memory difficulties
- ☐ disorganization
- ☐ difficulty with attention
- ☐ lose things frequently
- ☐ easily distracted
- ☐ forgetful
- ☐ fidgety
- ☐ feelings of restlessness
- ☐ act without thinking
- ☐ learning disability
- ☐ difficulty reading
- ☐ difficulty writing
- ☐ difficulty understanding what others say

INTERPERSONAL STRESSES

- ☐ lonely or isolated
- ☐ difficulty with coworkers
- ☐ difficulty with boss
- ☐ difficulty with family
- ☐ difficulty with friends

REACTIONS/LIFESTYLE

- ☐ too emotional
- ☐ under emotional
- ☐ like to be center of attention
- ☐ hard to trust others
- ☐ feel people talk about me
- ☐ avoid people when possible
- ☐ fear of criticism
- ☐ difficulty with decisions
- ☐ fear others will abandon me
- ☐ difficulty doing things on own
- ☐ perfectionistic
- ☐ overly focused on work
- ☐ rigid/stubborn
- ☐ fluctuating, unstable relationships
- ☐ reckless
- ☐ feelings of emptiness
- ☐ difficulty following rules
- ☐ physically aggressive
- ☐ preoccupied with fantasies of success
- ☐ special talents
- ☐ eccentric

Please elaborate on any items above and specify any other concerns. _____

Family History

HOUSEHOLD

List household members' names, ages, and any concern you may have.

	<u>Name</u>	<u>Age</u>	<u>Relationship</u>	<u>Medical/School/Behavior concern</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

MARITAL STATUS

___ Single ___ Engaged ___ Married ___ Re-married ___ Separated ___ Divorced ___ Widowed

Spouse's age ___ Spouse's occupation _____

Length of relationship _____

Describe strengths of current relationship _____

Describe areas of concern or incompatibility in the relationship _____

Give details of any previous marriages (length, children) _____

HISTORY OF EXTENDED FAMILY

Parents

Mother's occupation _____ Highest grade completed _____

Father's occupation _____ Highest grade completed _____

Parental marital status: ___ Not Married ___ Married ___ Separated ___ Divorced ___ Widowed

If applicable, your age at time of parental separation or death _____

Siblings

Number of siblings ___ Your birth order: ___ youngest ___ middle ___ oldest ___ other

Extended Family History

Please indicate with a check mark whether there is a family history of any of the following difficulties. Include parents, siblings, grandparents, aunts, uncles, and cousins. If present, please specify relationship.

<u>Difficulty</u>	<u>Family Member's Relationship To You</u>
☐ Mental Retardation	_____
☐ Attention Deficit Disorder/Attention Problems	_____
☐ Tourette's Syndrome or Tic Disorder	_____
☐ Learning Problems/Failure	_____
☐ Communication Difficulties	_____
☐ Autism/Autistic Spectrum	_____
☐ Anxiety Problems	_____
☐ Obsessive Compulsive Disorder	_____
☐ Depression	_____
☐ Suicide Attempt, Suicide Completed	_____
☐ Sexual or Physical Abuse	_____
☐ Drug Abuse	_____
☐ Alcoholism	_____
☐ Legal Difficulties	_____
☐ Schizophrenia	_____
☐ Psychiatric Hospitalization	_____
☐ Use of Psychiatric Medication	_____
☐ Thyroid Problems	_____
☐ Genetic/Metabolic Disorders	_____
☐ Bipolar Disorder	_____
☐ Personality Disorder	_____

SELF-DESCRIPTION

Please give a word-picture of yourself as you would be described by:

- (a) spouse or significant other _____
- (b) your best friend _____
- (c) someone who dislikes you _____
- (d) self-description _____

ADDITIONAL COMMENTS

Please use the space below to describe any other information you feel would be helpful to us in understanding your concerns.
