



ADULT HISTORY QUESTIONNAIRE

Please complete form before your visit.

TODAY'S DATE: _____

PATIENT 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 (_____) _____

Presenting Concerns

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:

Counselor

Dates Seen

Records Available?

Medical Development History

Primary Care Physician: Name _____

Address _____

Phone (_____) _____

Present or Chronic Illnesses (including any allergies):

Current Medications/Vitamins (indicate dosage):

Past Psychiatric Meds

Dose

Dates/Response

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

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

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
- ☐ loses 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

Family History

HOUSEHOLD

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

Name	Age	Relationship	Medical/School/Behavior concern
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.

Difficulty

- ☐ Attention Deficit Disorder
- ☐ Tourette's Syndrome or Tic Disorder
- ☐ Mental Retardation
- ☐ 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
- ☐ Thyroid Problems
- ☐ Genetic Metabolic Disorders
- ☐ Bipolar Disorder
- ☐ Personality Disorder

Family Member's Relationship To You

SELF-DESCRIPTION

- (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.
