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 where 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: Counselor Dates Seen

Records Available?

_____
_____

_____
_____
_____
_____
_____
_____

Medical Development History Primary Care Physician: Name _____ Address _____
_____ Phone (_____)_____ Present or Chronic Illnesses:
_____
_____
_____
_____ Current Medications (indicate dosage and prescribing physician):
_____
_____
_____
_____ Past Psychiatric Medications: Medication Dose Response Why stopped
_____
_____
_____
_____
_____
_____

Allergies:
_____
_____

Please indicate with a check mark if your childhood/adolescent/young

adult history includes any of the following: ____ birth complications ____ major childhood illnesses ____ major childhood injuries ____ major childhood stresses ____ head injury (major or minor) ____ seizures

____ substance or alcohol abuse ____ childhood anxiety ____ childhood depression ____ allergies____ attention difficulties ____ victim of sexual abuse ____ victim of physical abuse ____ difficult family situation ____ problematic childhood/adolescence ____ childhood behavior problems

____ childhood legal problems ____ learning disabilities ____ parental separation/divorce ____ 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.
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 _____) ____ 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 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.

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 ____ 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

Family Member's Relationship To You _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____

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.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____