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ADULT HISTORY QUESTIONNAIRE

CONFIDENTIAL

The purpose of this questionnaire is to obtain background data concerning you. By completing this confidential form as fully as possible, you are assisting with this evaluation and reducing the time required to meet with you to obtain this information. I appreciate your cooperation and patience.

Client's name: ____ Date: _____________

Gender: __ F ____ M Date of birth: _____ Age: ___________

Form completed by (if someone other than client): ________________________________

Address:____ City: _______State: _____Zip: ________

Phone (home): _________________ (work): ________________ ext: _________

If you need any more space for any of the questions please use the back of the sheet.

Primary reason(s) for seeking services:

___ Anger Management ___ Anxiety ___ Coping ___ Depression

___ Eating Disorder ___ Fears/phobia ___ Mental Confusion ___ Sexual Concerns

___ Sleeping Problems ___ Addictive Behaviors ___ Alcohol/ Drugs ___ Parenting

___ Other Mental Health Concerns (specify): ____

Family Information

Relationship		Name		Age		Living? Yes		Living? No		Living with you? Yes		Living with you? No
Mother:												
Father:												
Spouse:												
Children:												

Significant others (e.g., brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.)

						Living?				Living with you?		
Relationship		Name		Age		Yes		No		Yes		No

Marital Status (more than one answer may apply)

__ Single

___ Divorce in process
Length of time: _______

___ Unmarried, living together
Length of time: ________

__ Legally married
Length of time:

___ Separated
Length of time: __________

___ Divorced
Length of time: ________

__ Widowed
Length of time: ________

___ Annulment
Length of time: _______

Total number of marriages: ________

Assessment of current relationship (if applicable): ____ Good _____ Fair _________ Poor

Parental Information

__ Parents legally married

__ Parents have ever been separated

__ Parents ever divorced

___ Mother remarried: Number of times: __

___ Father remarried: Number of times: __

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.)

Development

Are there special, unusual, or traumatic circumstances that affected your development?

______ Yes _____ No

If Yes, describe: ____________________

Has there been history of child abuse? ___ Yes ____ No

If Yes, which type(s)? ________ Sexual ___ Physical ____ Verbal

If Yes, the abuse was as a: __________ Victim ___ Perpetrator

If Yes, was the abuse reported to a Child Protective Services or similar agency?

Other childhood issues: ___ Neglect ___ Inadequate nutrition

If Yes, was the neglect reported to a Child Protective Services or similar agency?

____ Other (please specify): ____

Comments regarding childhood development: ____________________

____

Social Relationships

Check how you generally get along with other people: (check all that apply)

__ Affectionate ___ Aggressive ___ Avoidant ___ Fight/argue often ___ Follower

__ Friendly ___ Leader ___ Outgoing ___ Shy/withdrawn ___ Submissive

__ Other (specify): ____

Sexual orientation: _______________ Comments: ____ ___

Sexual dysfunctions? _______ Yes _______ No

If Yes, describe: ____________________

Sexual Concerns? ___ Yes __ No

If Yes, describe: ____________________

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? ____________________________

Are you experiencing any problems due to cultural or ethnic issues? ___ Yes ________ No

Spiritual/Religious

How important to you are spiritual matters? ___ Not ___ Little ___Moderate ___Much

Are you affiliated with a spiritual or religious group? ___ Yes ___No

If Yes, describe: ______________________________

Were you raised within a spiritual or religious group? ___ Yes ___No

If Yes, describe: ______________________________

Would you like your spiritual/religious beliefs incorporated into the counseling? ___ Yes ___ No

If Yes, describe: ______________________________

Legal

Current Status

Are you involved in any active cases (traffic, civil, criminal)? ___ Yes ___ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: _____

____

Are you presently on probation or parole? ___Yes ___ No

If Yes, describe: ______________________________

Past History

Traffic violations: ___ Yes __ No DWI, DUI, etc.:___ Yes ___ No

Criminal involvement: ___ Yes ___No Civil involvement: ___ Yes ___ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

Education

Fill in all that apply:

Years of education: ________________Currently enrolled in school? ___ Yes ___ No

__ High school grad/GED

__ Vocational: Number of years: _________ Graduated: ____ Yes ___ No Major:

__ College: Number of years: ________ Graduated: ___ Yes ___ No Major:
__ Graduate: Number of years: ________ Graduated: ___ Yes ___ No Major:

Other training: ______________________________

____

Special circumstances (e.g., learning disabilities, gifted): ______________________________

____

Military

Military experience? ___ Yes ___ NoCombat experience? ___ Yes ___ No

Where: ______________________________

Branch: ______________ Discharge date: ______________

Date drafted: ______________ Type of discharge: ______________

Date enlisted ______________ Rank at discharge: ______________

Employment

Employer (Most recent first)	Dates	Title	Reason for Leaving

Currently: ___FT ___ PT ___ Temp ___ Laid-off ___ Disabled ___ Retired
___Social Security ___ Student ___ Other (describe): ______________________________

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	**How often now?**	**How often in the past?**

Medical/Physical Health

___ AIDS	___ Drug abuse	___ Osteoporosis
___ Alcoholism	___ Epilepsy	___ Pneumonia
___ Abdominal pain	___ Ear infections	___ Rheumatic Fever
___ Abortion	___ Eating problems	___ Sexually transmitted diseases
___ Allergies	___ Fainting	___ Sleeping disorders
___ Anemia	___ Fatigue	___ Sore throat
___ Appendicitis	___ Frequent urination	___ Scarlet Fever
___ Arthritis	___ Headaches	___ Sinusitis
___ Asthma	___ Hearing problems	___ Smallpox
___ Bronchitis	___ Heart	___ Stroke
___ Bed wetting	___ Hepatitis	___ Sexual problems
___ Cancer	___ High blood pressure	___ Tonsillitis
___ Chest pain	___ Kidney problems	___ Tuberculosis
___ Chronic Pain	___ Measles	___ Toothache
___ Colds/Coughs	___ Mononucleosis	___ Thyroid problems
___ Constipation	___ Mumps	___ Vision problems
___ Chicken Pox	___ Menstrual pain	___ Vomiting
___ Dental problems	___ Miscarriages	___ Whooping Cough
___ Diabetes	___ Neurological disorder	___
___ Diarrhea	___ Nose bleeds	___ Other (describe):
___ Dizziness	___ Osteopenia	___________________

Physician's name and contact information: ____

____

List any current health concerns: ____

List any recent health or physical changes: __________________________________

Current prescribed medications	Dose	Dates	Purpose/Side effects

Current over-the counter meds	Dose	Dates	Purpose/Side effects

Are you allergic to any medications or drugs? ___ Yes ____________ No

If Yes, describe: ______________________________

	Date	Reason	Results
Last physical exam			
Last doctor's visit			
Last dental exam			
Most recent surgery			
Other surgery			

Upcoming surgery: ______________________________

Family history of medical problems: ______________________________

Please check if there have been any recent changes in the following:
__ Sleep patterns ___ Eating patterns ___ Behavior ___ Energy level
__ Physical activity level ___ General disposition ___ Weight ___ Nervousness/tension
Describe changes in areas in which you checked above: __________________________

Nutrition

Meal	How often ? (times per week)	Typical foods eaten
Breakfast		
Lunch		
Dinner		
Snacks		
Comments:		

Chemical Use History

	Method of use and amount	Freq. of use	Age of first use	Age of last use	Used within the last 48 hours?		Used within the last 30 days?	
					Yes	No	Yes	No
Alcohol								
Barbiturates								
Valium/Librium								
Cocaine/Crack								
Heroin/Opiates								
Marijuana								
PCP/LSD/Mesc.								
Inhalants								
Caffeine								
Nicotine								
Over the counter								

Presc. Drugs								
Other drugs								

Substance(s) of preference
1. ________________________________ 3. ________________________________
2. ________________________________ 4. ________________________________

Substance Abuse Questions

Describe when and where you typically use substances:

Describe any changes in your use patterns:

Describe how your use has affected your family or friends (include their perceptions of your use):

Reason(s) for use:
__ Addicted ___ Build confidence ___ Escape ___ Self-medication
__ Socialization ___ Taste ___ Other (specify): _______________

How do you believe your substance use affects your life?

Who or what has helped you in stopping or limiting your use?

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?
__ Yes __ No If Yes, describe: ____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ___ Yes ___No

If Yes, describe:

Have you had adverse reactions or overdose to drugs or alcohol? (describe):

Does your body temperature change when you drink? ___Yes ___ No

If Yes, describe:

Have drugs or alcohol created a problem for your job? ___ Yes ___ No

If Yes, describe: ______________________________

Counseling/Prior Treatment History

Information about **client** (past and present):

	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment			
Suicidal thoughts/attempts			
Drug/alcohol treatment			
Hospitalizations			
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)			

Information about **family/significant others** (past and present):

	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment			
Suicidal thoughts/attempts			
Drug/alcohol treatment			
Hospitalizations			
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)			

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

___ Aggression
___ Alcohol dependence
___ Anger
___ Antisocial behavior
___ Elevated mood
___ Fatigue
___ Gambling
___ Hallucinations
___ Phobias/fears
___ Recurring thoughts
___ Sexual addiction
___ Sexual difficulties

___ Anxiety
___ Avoiding people
___ Chest pain
___ Cyber addiction
___ Depression
___ Disorientation
___ Distractibility
___ Dizziness
___ Drug dependence
___ Eating disorder
___ Heart Palpitations
___ High blood pressure
___ Hopelessness
___ Impulsivity
___ Irritability
___ Judgment errors
___ Loneliness
___ Memory impairment
___ Mood shifts
___ Panic attacks
___ Sick often
___ Sleeping problems
___ Speech problems
___ Suicidal thoughts
___ Thoughts disorganized
___ Trembling
___ Withdrawing
___ Worrying
___ Other (describe): ______________________

Briefly discuss how the above symptoms, or additional symptoms not listed, and how they impair your ability to function effectively:

____
____
____
____
____

Any additional information that would assist us in understanding your concerns or problems:

____
____
____
____
____

What are your goals for therapy?

Do you feel suicidal at this time? _____ Yes _____ No

If Yes, explain: