ADULT HISTORY QUESTIONNAIRE

Please answer the following questions carefully and completely.
The questionnaire will be reviewed with you, so it will be possible to discuss your answers if necessary.

CLIENT INFORMATION:

Name: _____ Gender: _____

Age: _____ Date of Birth: _____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Phone (Home) _____ (Work) _____ (Cell) _____

Email Address: _____

Preferred Mode of Contact: ____Email ____Work ____Cell ____Home

Marital Status: _____ Never Married _____ Domestic partnership _____ Married

_____ Separated _____ Divorced _____ Widowed

Spouse/Partner Name: _____ Years Together: _____

If divorced, list previous relationships:

Previous Spouse: _____ Years Together: _____

Date Divorced: _____ Reason: _____

Previous Spouse: _____ Years Together: _____

Date Divorced: _____ Reason: _____

Please list any children:

Name	*Age*	*Name*	*Age*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Referral Source: _____

CURRENT EMPLOYMENT:

Employer Name: _____ Job Title: _____

Hours Worked per Week: _____ Years at Job: _____

PROBLEMS AND CONCERNS:

Please list, in order of urgency, the problem(s) for which you are seeking support:

A. _____

B. _____

C. _____

D. _____

E. _____

Family mental health history:	**Please circle**	**List family member**
Alcohol/substance abuse	yes/no	_____
Anxiety	yes/no	_____
Depression	yes/no	_____
Domestic Violence	yes/no	_____
Eating Disorder	yes/no	_____
Obsessive Compulsive Disorder	yes/no	_____
Schizophrenia	yes/no	_____
Suicide Attempts	yes/no	_____

MEDICAL HISTORY:

Please list current health/medical conditions:_____

_____

_____

Please list medications are you currently taking and provide dates:

Have you ever been prescribed psychiatric medication?

_____No

_____Yes, please list and provide dates:_____

Are you currently experiencing any overwhelming sadness, grief, or depression?_____

_____

Are you currently experiencing anxiety, panic attacks or phobias?_____

_____

How often do you engage in recreational drug use?

____Daily _____Weekly _____Monthly _____Infrequent _____Never

How often do you drink alcohol?

____Daily _____Weekly _____Monthly _____Infrequent _____Never

Have you ever previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

_____ No

_____ Yes, Previous therapist/practitioner:_____

Service provided and time seen: _____

Have you ever received a psychological or neuropsychological evaluation?

_____ No

_____ Yes, what was your diagnosis? _____

Who conducted the evaluation? _____ Date: _____

TRAUMA HISTORY:

6. Please describe any history of trauma, including natural disasters, physical abuse, sexual abuse, physical and emotional neglect, verbal abuse, exposure to family violence, substance use by caregivers, imprisonment of caregivers, long-term separation from caregivers, death of a close family member or friend, parent separation or divorce, etc.

ACADEMIC HISTORY:

1. Please list below any schools you have attended:

School Location (City, State) Highest Level/Degree Obtained Dates Attended

_____

_____

_____

_____

_____

_____

2. Have you ever repeated a grade? Yes ____ No _____ If yes, what grade and what was the reason? _____

3. Please indicate if you ever received any of the following services in school:

_____Head Start _____Early reading (Title I) _____Speech Therapy

_____Physical Therapy _____Occupational Therapy _____School Counselor

_____Resource Room _____Content Mastery Center _____Special Education

Please list any academic subjects that were addressed with these services:

_____

4. Please indicate your overall school performance:

Subject	**Failing**	**Below Average**	**Average**	**Above Average**
Reading				
Writing/Spelling				
Mathematics				
Science				
Social Studies				
Other (specify):				

SOCIAL FUNCTIONING:

1. Please list your sources of support: _____

_____

2. How many close friends do you have?

___ No close friends

___ 1-2 close friends

___ Several close friends

What activities do you enjoy doing together? _____

_____

3. Please list any organizations, clubs, teams, or groups that you belong to:

_____

_____

4. Please list your special interests, hobbies, or extracurricular activities:

_____

_____

5. What are some of your strengths: _____

_____

6. What are some of your weaknesses: _____

_____

OTHER IMPORTANT INFORMATION:_____

_____

_____

_____

_____