Adult Questionnaire

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Name Date of Birth Age

Today's Date PCP Marital Status

Employment Status Place of Birth

Best way to contact you:

Please list 2 emergency contacts: Name, Relationship, and Phone Number.

Name Relationship Number

Name Relationship Number

The information you relate in this questionnaire will help your therapist with background information that should help save time in session and address your problems more efficiently.

Presenting Problem

What prompted you to seek counseling at this time? Please provide some detail in your answer.

Why did you decide to come into treatment right now?

When did this first become a problem?

Current stressors in your life: (money, relationships, work, trauma, family, etc.)

Are you experiencing any of the following symptoms?

Indicate those that apply:

- Depressed mood
- Weight loss / gain
- Loss of energy
- Attention / Concentration Problems
- Fatigue
- Excessive guilt
- Irritability
- Fear of losing control
- Sleep impairment (too much / too little)
- Social withdrawals
- Tingly sensation in hands or feet
- Shortness of breath
- Constant worry
- Panic attacks
- Anxiety
- Chest pain
- Sensation of choking
- Feelings of unreality
- Dizziness
- Health palpitations
- Hyper alert
- Muscle tension
- School misconduct
- Dropping grades
- Cutting
- Drug use
- Excessive drinking
- History of head injury
- Hallucinations (voices, visual)
- Violent thoughts or behavior
- Increased/ Decreased sex drive
- Extreme mood swings
- Obsessive thoughts
- Compulsive behavior
- Feelings of worthlessness
- Suicidal thoughts

List all the therapists and psychiatrists you have seen in the past 10 years, how long you saw each, and general reason:

If you have seen a therapist or psychiatrist previously, will you sign a release of information? (Y/N)

Have you ever been hospitalized for emotional difficulties before? If yes, what year(s) and for how long?

Have you ever attempted to take your own life before? If yes, when and how many times?

Health

Please list any medication you are currently taking, and what you are taking them for:

Are you allergic to any medications?

Do you have any ongoing or chronic medical conditions?

Indicate those that apply:

- Diabetes
- Fibromyalgia
- Lupus
- Chronic pain
- Heart condition
- Thyroid
- Cancer
- Sleep Apnea
- Seizures
- Parkinson's disease
- Huntington's disease
- Other neurological problem

Other:

Family

What is your **current** marital status?

Please indicate:

Married Divorced Widowed Separated

How many times have you been married?

If married, for how long?

Please describe the quality of your married:

Please list the names and ages of your **children**, if applicable. Indicate which are biological or step-children, and whether they currently live with you:

Name(s)	Age(s)	Biological/step	Living with you?

Please list the names, relationships, and ages of all **other** persons living with you in your household:

Please list any people or pets you have lost in the past 5-10 years, and approximate date:

Family of Origin History

Growing up, was there any child abuse in your family?

Please indicate:

Physical   Emotional   Sexual   No

If you parents divorced, at what age were you?

List the names and ages of your brothers and sisters, if applicable. Designate if they are full, half, or step:

Were you adopted? (Y/N)

Name(s)	Age(s)	Full/Half/Step

Can you recall if either parent, a grandparent, or sibling suffered from any of the following? If so please indicate:

Depression

- Father
- Mother
- Siblings
- Maternal Grandparents
- Paternal Grandparents

Anxiety

- Father
- Mother
- Siblings
- Maternal Grandparents
- Paternal Grandparents

Bi-Polar Disorder

- Father
- Mother
- Siblings
- Maternal Grandparents
- Paternal Grandparents

Substance/Alcohol Abuse

- Father
- Mother
- Siblings
- Maternal Grandparents
- Paternal Grandparents

Domestic Violence

- Father
- Mother
- Siblings
- Maternal Grandparents
- Paternal Grandparents

Miscellaneous

How important are religious beliefs to you?

	Very	Significant	Average	Barely	Not At All
Importance					

Religious or Church Affiliation:

If a parent, spouse, or child has died, please indicate who and when (month / year) this happened.

Can you recall any traumatic event that you experienced in the past? (e.g. assault, rape molestation, kidnapping, natural disaster, server physical accident, etc.)

Has domestic violence ever been a problem in your adult life? (Y/N)

Please list 2 emergency contacts with name, relationship, and phone number:

Name Relationship Phone Number

Name Relationship Phone Number

How often do you drink alcohol?

	Daily	A few times a week	Weekly	Rarely	Not At All
Frequency					

How much alcohol do you drink on average at any one time?

Have you ever had to cut back on your drinking? (Y/N)

Have you ever felt guilty about your alcohol consumption? (Y/N)

Have you ever sought treatment for alcohol (or drug) use? (Y/N)

Does your alcohol use pose any problem for yourself, your family, or work? (Y/N)

Are you currently abusing any street drug(s)? If yes, please list:

Is there a history of street drug abuse? If yes, please describe:

How many caffeinated drinks do you consume per day?

Do you smoke cigarettes? If so, how many per day?

Are you experiencing any type of legal problem? Explain:

Have you ever been incarcerated for any prior problem?

Is there a history of violence or use of weapons?

What are 2 or 3 main goals you would like to accomplish in therapy?