Confidential Adult Questionnaire

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Client Name: _____ Date: _____

Please complete this form to help your clinician as he/she talks with you regarding your problems. If you are unsure about the answers to any of these questions, please discuss them with your clinician.

Please check all of the following problems/symptoms which apply to you.

[ ] Panicky feelings
[ ] Nervousness
[ ] Anxiety
[ ] Fears
[ ] Procrastination
[ ] Nervous tics
[ ] Driven to perform certain behaviors
[ ] Headaches
[ ] Chest pains
[ ] Rapid heartbeat
[ ] Dizziness
[ ] Excessive sweating
[ ] Appetite problem
[ ] Weight loss/gain
[ ] Bowel/stomach trouble
[ ] Bingeing
[ ] Purging
[ ] Muscle tension
[ ] Pain
[ ] Depression
[ ] Unhappiness
[ ] Seasonal variations in mood
[ ] Tearfulness
[ ] Loss of interest
[ ] Boredom
[ ] Nightmares
[ ] Sleep problems
[ ] Menopausal
[ ] Sexual Problems
[ ] Drug or alcohol abuse
[ ] No sense of purpose
[ ] Shyness
[ ] Loneliness
[ ] Relationship problems
[ ] Educational problems
[ ] Financial problems
[ ] Career issues
[ ] Low Self-esteem
[ ] Temper outbursts
[ ] Anger problems
[ ] Loss of control
[ ] Suspicious of others
[ ] Hearing unidentified voices or sounds
[ ] Guilt
[ ] Jealousy
[ ] Difficulty making decisions
[ ] Memory problems
[ ] Reduced concentration
[ ] History of abuse
[ ] Flash backs
[ ] Time loss
[ ] Feeling out of body
[ ] Feeling unreal
[ ] Sensitivity to noise or lights
[ ] Racing thoughts
[ ] Excessive worry
[ ] Fatigue
[ ] Suicidal thoughts
[ ] Homicidal thoughts

Family History

Please circle the number best describing the family in which you grew up:

Warm and Accepting — Distant or Hostile

1 2 3 4 5 6 7 8 9

Has anyone in your family suffered from: (please check all that apply)

____Depression ___Anxiety ___Suicide ___Bipolar Disorder ____Psychosis ___Alcoholism ____Substance Abuse

Relative:_____ Which issue(s):_____

Relative:_____ Which issue(s):_____

Relative:_____ Which issue(s):_____

Was your family/home disrupted by serious illness/accident/death/separation/divorce?

If yes, please describe _____

_____

Childhood History

As a child did you have any problems with any of the following?

____Learning Disabilities Age/Grade_____ ____School Fears Age/Grade_____

____Physical Abuse Age/Grade_____ ____Depression Age/Grade_____

____Sexual Abuse Age/Grade_____ ____Hyperactivity Age/Grade_____

If you had any other major childhood issues please describe:

_____

_____

Mental Health

Have you ever attempted suicide? ____ No ____Yes

Do you currently have suicidal thoughts? ____ No ____Yes

Do you ever feel angry enough to hurt someone else, physically? ____No ____Yes

Have you experienced any unusually severe stressors during the past year? ____No ____Yes

If you answered yes to any of the above, please describe:

_____

_____

_____

Previous Counseling:

Have you ever seen anyone or are you currently seeing anyone for:

Individual Therapy ___No ___Yes Marital/Couples Therapy ____No ____Yes Group Therapy ____No ____Yes

Please describe your experience:_____

_____

Job Satisfaction*:* ____Very Satisfied ____Fairly Satisfied ____Not At All Satisfied

What is your job/profession? _____

Have you ever taken work leave for mental health/chemical dependency reasons? ____No ____Yes How Long?_____

Medical/Lifestyle History

Current health: _____ Poor _____Fair _____Good _____Excellent

Do you have any medical problems or diseases? ____No ____Yes If so, please describe: _____

_____

_____

Did you ever have a head injury? _____ No _____Yes Have you ever had seizures? _____No _____Yes

If so, when?_____

Medication(s) currently using:

Medication	Dosage	Prescribed for	How Long?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Hospitalizations (Psychiatric/Chemical Dependency)

Date(s)	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

Alcohol Use

How often do you use alcohol? _____None _____Monthly _____Weekly ____Daily

On the days that you drink, how many drinks do you usually have?

_____Less than 2 _____2-5 _____5 or more

Do you consider it a problem? _____No _____Yes Do others consider it a problem? _____No ____Yes

(If yes, please explain)

_____

Have you had problems with alcohol in the past? ___No ___Yes When? _____

Nicotine Use

Do you smoke or use tobacco? _____No _____Yes, how much per day? _____

Caffeine Use

How many cups of caffeinated coffee/tea/soda do you drink per day?_____

Drug Use

Name of substance:_____ ____Occasionally ____Weekly ____ Daily

Do you use misuse prescription medicine? ____No ____Yes

***Legal History*:** ____None _____Litigation _____Arrest _____Victimization

Are you currently involved in a court case? ____No ____Yes Explain:_____