

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.

What is the primary reason you are seeking help at this time? _____

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

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

Mental Health

Is there a family history of (check all that apply):

Depression Anxiety Suicide Bipolar Disorder Psychosis Alcoholism Substance Abuse

If yes, please describe the relationship to you and the problem:

Concern _____ Which relatives _____

Concern _____ Which relatives _____

Concern _____ Which relatives _____

Have you attempted suicide? No Yes

Do you currently have suicidal thoughts? No Yes

Do you ever feel angry enough at home, work, or school to do something you might regret?

No Yes

Childhood History

As a child did you have any problems with:

Age

Learning disabilities No Yes _____

Hyperactivity No Yes _____

School fears No Yes _____

Depression No Yes _____

Sexual or physical abuse No Yes _____

Did you have any other major childhood (0-17 years) school, learning, or emotional problems?

No Yes If so, please describe: _____

Family History

Which of the following best describes the family in which you grew up?

Warm and Accepting		Average		Distant, Hostile and Fighting				
1	2	3	4	5	6	7	8	9

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

No Yes If yes, please describe _____

Previous Counseling or Chemical Dependency Services:

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

Individual Therapy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Marital/Couples Therapy	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Group Psychotherapy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Sex Therapy	<input type="checkbox"/> No	<input type="checkbox"/> Yes.

Facility/Counselor Name	Month/Year Seen	Reason Seen	Helpful?
_____	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes
_____	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes
_____	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes

Have you experienced any unusually severe stresses during the past year? Yes No

If yes, please describe: _____

Job Satisfaction: Very Satisfied Fairly Satisfied Not At All Satisfied

Have you ever taken work leave for mental health/chemical dependency problems?

No Yes How Long? _____

What is your job/profession? _____

Medical/Lifestyle History

Current health Poor Fair Good Excellent

Do you have any medical problems or diseases?

Did you ever have a head injury? No Yes

Did you ever have seizures? No Yes

Medication(s) currently used:

Medication/Dose	Date Prescribed	Why Prescribed	Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you take any herbal medications? No Yes, please name _____

Past Hospitalizations (Psychiatric/Chemical Dependency)

Date(s)	Reasons	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

Do you have problems at work/school because of drinking or drug use? No Yes

Have you had problems with alcohol in the past? No Yes

Nicotine use

Do you smoke or use tobacco now? No Yes, how much per day? _____

Have you smoked or used tobacco in the past? No Yes

Caffeine

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

How many caffeinated soft drinks? _____

Drug use

Marijuana: None Occasionally Daily

Weekly

Do you use other non-prescription substances? No Yes, what substances? _____

Do you take prescription substances more than prescribed? No Yes

Legal History: None Litigation Arrest Victimization, specify _____

Are you currently involved in a court case? No Yes, which type? _____