Behavioral Health Clinic

ADULT QUESTIONNAIRE

Please complete this 2-sided questionnaire. Write N/A when a question is not applicable.

Date: _____ Full Name: _____
Birth Date: _____ Age: _____ Sex: _____
Home Address: _____ Telephone: _____
City: _____ State: _____ Zip Code: _____ Email: _____
Name of your employer: _____ Job title: _____
Please state why you scheduled this appointment and what you hope to gain from working with us:
_____
_____

REASON FOR REFERRAL

Who referred you for evaluation/treatment? _____
On a scale of 1 to 10 (1 being not at all a problem and 10 being a very severe problem), please rate the severity of your problem(s): _____ When did you first notice the problem? _____
_____
What have you been told with regard to the problem? _____
_____

TREATMENT

What kinds of things have you tried in order to take care of the problem? _____
_____
Have you seen other professionals? ( ) Yes ( ) No
If yes, who, when, where, and to what result? _____
_____

MARRIAGE AND FAMILY

Current marital status:
( ) Single ( ) Dating ( ) Engaged ( ) Married ( ) Domestic Partnership ( ) Separated ( ) Divorced ( ) Widowed
Describe past significant relationships and their length: _____
_____
Full name of current spouse/significant other: _____
Spouse/significant other's age: _____ Spouse/significant other's birth date: _____/_____/_____
Spouse/significant other's employer: _____ Job title: _____
Are there any problems in your relationship with your spouse/significant other? ( ) Yes ( ) No
If yes, please describe/explain: _____
_____
What kinds of activities do you do just with your spouse/significant other? _____
_____
Do you have Children? ( ) Yes ( ) No

CHILDREN

Name of child	Biological, Step, or Adopted	Date of Birth	School Level/Occupation

Are there any problems in your relationship with your children? ( ) Yes ( ) No
If yes, please describe/explain: _____

What kinds of activities do you do together with your children? _____

What kinds of activities do you do as a family? _____

FAMILY OF ORIGIN

Please complete as applicable.	Name	Age	Occupation/School	Living or Deceased
Mother				
Father				
Step-Mother				
Step-Father				
Siblings				
Step-Siblings				

Are there any problems in your relationship with your mother? ( ) Yes ( ) No
If yes, please describe: _____

Are there any problems in your relationship with your father? ( ) Yes ( ) No
If yes, please describe: _____

Are there any problems in your relationship with your siblings? ( ) Yes ( ) No
If yes, please describe: _____

FAMILY BACKGROUND

Has anyone in your family had any of the following:	Yes	No	Relationship to Client
Alcoholism			
Anxiety attacks			
Arrests			
Behavior problems as a child			
Depression			
Dropped out of school or failed a grade			
Drug abuse			
Eating disorder (anorexia/bulimia)			
Epilepsy			
Huntington's disease			
Attention Deficit Hyperactivity Disorder (ADHD)			
Learning disabilities			
Mental retardation			
Migraine headaches			
Narcolepsy (sleep attacks)			
"Nervous breakdown"			
Obsessions or compulsions			
Panic attacks/agoraphobia			
Psych. hospitalization			
Suicide			
Tics or Tourette's Disorder			
Other:			

DEVELOPMENT

Did you have any language difficulties such as stammer, stutter, strange sounds, or problems in understanding?

( ) Yes ( ) No If yes, please explain: _____

_____

Were there any changes in your primary caretakers during the first 3 years of life? ( ) Yes ( ) No
If yes, how many times and please explain: _____

_____

Were you attached to any inanimate objects (e.g., blanket, teddy bear, etc.)? ( ) Yes ( ) No
If yes, what object? _____
From age _____ to _____. Are you: ( ) Right-handed ( ) left-handed ( ) ambidextrous

EDUCATION

Last level of education completed: _____
Are you currently in school? _____ If so, for what degree? _____

PSYCHIATRIC HISTORY AND INFORMATION

Have you ever been treated at an outpatient clinic or hospitalized for mental health problems or problems with relationships? ( ) Yes ( ) No

If yes, please provide the following information:

Name of Therapist	Name of Clinic/Hospital	Dates of Treatment	Reason for Treatment

Has your spouse/significant other, children, or any other family members or extended family members experienced mental health problems? ( ) Yes ( ) No
If yes, please describe: _____

_____

Have you ever thought of committing suicide? ( ) Yes ( ) No
If yes, please explain: _____

_____

Have you ever attempted to take your life? ( ) Yes ( ) No
If yes, please explain: _____

_____

Have you had any thoughts about suicide recently? ( ) Yes ( ) No
If yes, please explain: _____

_____

Please describe your mood over the last seven days.

_____

_____

TESTING

Has there been intellectual or psychological testing or testing for learning disabilities done in the past? ( ) Yes ( ) No
If yes, please explain what testing was done, when it was done, where it was done, by whom it was done, and what the results of the testing were: _____

_____

SUBSTANCE ABUSE INFORMATION

Have you ever been treated at an outpatient clinic or hospitalized for alcohol/drug abuse? ( ) Yes ( ) No
If yes, please provide the following information:

Name of Therapist	Name of Clinic/Hospital	Dates of Treatment

Has your spouse/significant other, children, or any other family members or extended family members experienced a drug abuse/addiction? ( ) Yes ( ) No

If yes, please describe: _____
_____

Please complete as applicable.

Check if you used	Name of Chemical (Circle the applicable substance)	How much?	How often?	Duration	Age of First Use	Age of Last Use
	Beer, Wine, Liquor					
	Marijuana/Hashish					
	Amphetamines, Speed, Uppers, Ritalin, Dexedrine, Meth, Crank, Ephedrine					
	Cocaine, Crack, Rock					
	Inhalants (e.g. glue, aerosols, Glade, etc.), LSD, PCP					
	Mushrooms, Peyote					
	Heroine					
	Opium, Morphine, Codeine					
	Methadone					
	Pain Killers (e.g. Darvon, Midol)					
	Non-barbiturates: Restoril, Unis, sleeping pills					
	Barbiturates: Amytal, Luminol, Seconal, Nemputal, downers					
	Anti-Anxiety Agents: Valium, Librium, Ativan					
	Antipsychotic Agents: Mellaril, Risperidol					
	Anti-Depressants, Designer drugs: Cat, Special K, Ecstasy					
	Tobacco, chew					
	Other:					

Have you ever experienced blackouts or memory loss? ( ) Yes ( ) No
If yes, when? _____

Do you feel alcohol or drugs cause problems for you? ( ) Yes ( ) No
If yes, explain: _____

Has your family, friends, or employer ever objected to your drinking or drug use? ( ) Yes ( ) No
If yes, explain: _____

Have you ever attempted to cut down or stop drinking or drug use for a period of time? ( ) Yes ( ) No
If yes, explain: _____

LEGAL

Have you ever been arrested? ( ) Yes ( ) No

If yes, please list below:

Year Charge Sentence

_____
_____

MEDICAL HISTORY

Please provide the following information regarding the medical professionals you see:

Physician Name	Physician's Address	Date last seen by this physician

Have you had any surgeries, hospital stays, or other serious illnesses? ( ) Yes ( ) No

If yes, please provide the information below:

Describe medical problem	Name of hospital/clinic	Date of event/stay/illness

CURRENT MEDICAL INFORMATION

	Yes	No	Comments
Are your immunizations up-to-date?			
Do you have any hearing problems or problems with ear infections?			
Do you have any eye problems?			
Do you have any of the following:			
Dizziness			
Double vision			
Fainting spells			
Loss of consciousness (blackout)			
Memory problems			
Momentary lapses of consciousness			
Severe headaches			
Sleep disturbances			
Trance-like episodes			
Tremors			
Troubles walking			
Incoordination			
Other			
Do you have problems with:			
Bones			
Digestive tract			
Genito-urinary system			
Heart and blood vessels			
Hormone system			
Muscles			
Respiratory system			

For women only:

a. Age of menses onset? _____
b. Are they regular? _____
c. PMS? _____
d. Age of menopause onset? _____

MEDICATIONS

Are you allergic or sensitive to any medications? ( ) Yes ( ) No

If yes, please list the name(s) of the medication(s): _____

_____

Have you received medications in the past for emotional, learning, or behavior problems? ( ) Yes ( ) No
If yes, please complete the box below:

Your Age	Name of Medication	How long?

Are you taking medication(s) now? ( ) Yes ( ) No

If yes, please complete the box below:

Name of Medication	Dose	Is it helping?

PERSONALITY

For each of the pairs of opposites below, check the one choice which best describes how you USUALLY FEEL.

( ) Happy ( ) Sad	( ) Withdrawn ( ) Outgoing	( ) Controlled ( ) Impulsive
( ) Confident ( ) Unconfident	( ) Calm ( ) Nervous	( ) Hostile ( ) Friendly
( ) Patient ( ) Frustrated	( ) Independent ( ) Dependent	( ) Changing Moods ( ) Steady Moods
( ) Fearless ( ) Frightened	( ) Hyperactive ( ) Lethargic	( ) Interested ( ) Bored
( ) Violent emotions ( ) Even Temper	( ) Eats Well ( ) Problem eater	( ) No sense of humor ( ) Humorous

LEISURE TIME

Would you rather spend your spare time alone or with someone? _____
Would you rather spend your time inside or outside? _____
What would you most like to do during your spare time? _____
Do you have a preference to socialize mostly: ( ) with men ( ) with women ( ) both the same?
Are there any particular habits or behaviors that seem to get you in trouble with other people?

_____

_____

Describe your strengths (with regard to abilities, behavior, etc.):

_____

_____

_____

What things present the greatest difficulty for you?

_____

_____

Describe your favorite indoors activity:

_____

_____

Describe your favorite outdoors activity:

_____

_____

How do you get a long in groups?

_____

_____