Questionnaire for Adult Patients

The following questions are asked so that we can better understand you. This type of information is very helpful in making an accurate assessment and providing effective treatment. Please read the questions carefully and answer as fully as possible. We will discuss these questions in detail at the time of your intake appointment. Thank you.

PLEASE PRINT

CLIENT'S NAME _____ DATE _____

BIRTHDATE _____ AGE _____ EDUCATION _____

HOME ADDRESS _____

_____

PHONE (H) _____ (W) _____ (C) _____

MARITAL STATUS _____ EMPLOYMENT STATUS _____

REFERRED BY/How did you hear about us? _____

Primary Care Physician Name and Phone Number: _____

What are your concerns? Why is it that you are coming to see us?

_____

_____

_____

_____

What questions do you have that you hope we can help you answer? _____

_____

_____

_____

_____

What strategies have you tried to help? _____

_____

_____

_____

_____

What treatment, if any, have you received for the above problems? _____

_____

_____

_____

_____

Have you ever been previously evaluated for a similar problem? YES_____ NO_____
If yes, please explain (**Please bring a copy of all reports to the evaluation**):

PRESENT MEDICAL STATUS

Current Health: _____ (Please rate poor, fair, good, excellent, etc.)

Present height: _____ weight: _____

Are you in any way physically ill at this time? YES__ NO__

Do you exercise? YES__ NO__

Please list any medication you are currently taking:

Medication	Dose (e.g. 20mg four times a day)	Date Started

Do you wear glasses or contacts? YES NO Date of last eye exam: _____

_____

Do you have any difficulty hearing? YES NO Date of last hearing exam: _____

How would you describe your sleep? _____How many hours of sleep per night? _____

How would you describe your appetite? _____Have you gained or lost weight? _____

Please check all that apply to you:

_____ Mid-night awakenings
_____ Difficulty falling asleep
_____ Difficulty waking up
_____ Snores
_____ Nightmares/night terrors
_____ Recent weight gain or loss
_____ Low variety of foods in diet
_____ Poor/distorted body image

Do you currently smoke? _____ If yes, how much do you smoke per day and what brand of cigarettes? _____

If no, did you ever smoke? _____ If yes, how much did you smoke per day, for how long and what brand of cigarettes? _____

How many alcoholic beverages do you drink in an average week? _____

Have you ever had problems with alcohol use? YES _____ NO _____ If yes, have you ever received treatment? Please explain: _____

Do you use any other drugs recreationally? _____

Have you ever undergone any type of surgery? YES_____ NO_____ If yes, what type of operation did you have, how old were you, how long were you hospitalized, or was the surgery performed on an outpatient basis? _____

Have you suffered any type of head injuries? YES___ NO___ If yes, please indicate your age, how you were injured and whether or not consciousness was lost at the time of the incident, and if so, for how long: _____

Have you ever experienced seizures or convulsions? YES_____ NO_____ If yes, explain: _____

Have you ever been in a car accident? YES_____ NO_____ If yes, explain: _____

Do you have any allergies? YES_____ NO_____

FAMILY MEDICAL HISTORY

Please indicate if you or any member of your family has had any of the following problems.

Medical Condition	Yourself	Mother	Father	Sibling	Other (please specify)
ADHD					
Alcoholism					
Allergies					
Asthma					
Autism					
Cerebral palsy					
Dementia (Alzheimer's etc.)					
Depression					
Diabetes					
Drug Abuse					
Emotional Problems					
Encephalitis					
Epilepsy/Seizures					
Heart problems					
High Blood Pressure					
High Cholesterol					
Hydrocephalus					
Language Delay					
Learning Disability					
Lead poisoning/exposure					
Meningitis					
Mental illness					
Mental retardation					

Migraines					
Multiple sclerosis					
Reading Problems					
Sleep Disorder					
Thyroid problems					
Vision difficulties					
Other (please specify)					

Do you have any history of or are you currently a victim of sexual abuse, physical abuse or emotional abuse? YES _____ NO_____ If yes, please explain: _____

_____

_____

_____

Are you currently, or have you ever been involved in any type of professional mental health treatment (i.e., psychotherapy, family counseling, etc.)? YES _____ NO _____ If yes, please list:

Clinic/Provider Date(s) seen Contact Person Phone

_____

_____

_____

_____

EMPLOYMENT HISTORY

Occupation Place of Employment Years Worked

_____

_____

_____

_____

_____

Please list everyone in your immediate family as well any anyone else that lives in your home:

NAME AGE RELATIONSHIP LIVE IN YOUR HOME?

_____

_____

_____

Have you ever been arrested, charged with a crime or been in jail? If so, please explain and specify if you are currently on parole or probation

Are you currently represented by a lawyer for any legal proceedings? YES_____ NO_____

What are your preferred leisure activities?

What is your current social life like?

ACTIVITIES OF DAILY LIVING SKILLS:

Do you require any assistance with any basic daily living skills (i.e., toileting, dressing, grooming, eating)? YES_____ NO_____ If yes, please explain:

Please indicate if you need any help completing the following tasks:

Skill	**Need Help?**		**If yes, please explain:**
Bill Paying	Yes	No	
Financial Management	Yes	No	
Medication Administration	Yes	No	
Medication Management (i.e., reordering medications)	Yes	No	
Cooking	Yes	No	
Cleaning	Yes	No	
Grocery Shopping	Yes	No	
Driving	Yes	No	

EDUCATIONAL HISTORY:

Highest degree earned: _____

Name of high school: _____

Name of college/major: _____

Name of graduate school/ degree: _____

Did you fail or repeat any grades? YES_____ NO_____ If yes, which ones and for what reason(s)?

_____

_____

_____

_____

Did you fail any subjects? YES___ NO___ If yes, which ones? _____

_____

_____

Did you receive tutoring, help or special education services? YES _____ NO_____ If yes, specify type (i.e., self-contained class, resource room, reading or math lab, etc.):

_____

_____

_____

Please indicate if you or any member of your family has had any of the following educational problems.

Condition	**Self**	**Mother**	**Father**	**Sibling**	**Other (please specify)**
Attention problems					
Discipline problems					
Failing grades					
Failing subjects					
Math difficulties					
Reading difficulties					
Social situations					
Writing difficulties					

****

Please use this space for any additional information/comments you wish to share with us about yourself: