ADULT HISTORY QUESTIONNAIRE

Patient Name__________________ **Date___________**

CHIEF COMPLAINT/PRESENTING PROBLEM:

What brings you in today?____
____

MEDICAL

Please circle any/all medical conditions that you have currently:

None Asthma Chronic Pain Seizures Diabetes Heart Disease Obesity

Migraines Cancer Head trauma/accidents Hypertension Other_____________

Please list your medications: _________________ __________________ _______________________
________________ _________________________ ______________________ ____________________

Please list any medication allergies? ____

Do you take your prescribed medications as recommended (circle one)? **YES/NO**

Have you been in treatment for mental health issues or substance abuse before? **YES/NO**

-If yes, was it helpful? **YES/NO** Who was the most recent provider? ______________________

FAMILY MENTAL HEALTH HISTORY:

Do you have a family history of mental health issues (e.g. Depression, ADHD, Depression, Bipolar Disorder)? **YES/NO**

-If yes, please list your relationship to this person, and type: ___________________________

Do you have a family history of substance abuse? **YES/NO**

-If yes, please list your relationship to this person and type: ___________________________

RELATIONSHIPS/FAMILY: ARE YOU? Circle One

Single Married Separated/Divorced Remarried Widowed Living with Partner

Who do you live with currently? ____

Do you have any children? YES_______NO_______ How Many? ________

SUPPORT SYSTEM

Please circle the response that best describes your current relationships:

Overall Family Support:	GOOD	FAIR	POOR
Friends:	GOOD	FAIR	POOR
Other (e.g. community, work, etc.)	GOOD	FAIR	POOR

Do you participate in a spiritual practice that is supportive and meaningful to you? Yes_____ No_____

OCCUPATIONAL/EDUCATIONAL: What is your job?___________________

Please circle and/or check the response that best describes your current situation:

Full-time Part-time Student Homemaker Unemployed Disabled

Do you enjoy what you do? Yes_____ No_____ Highest grade completed is:___________

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Patient Name ________________________ **Date** __________

CURRENT/PAST STRESSORS (please circle)

o	Legal	Past/Current	Mild	Moderate	Severe
o	Financial	Past/Current	Mild	Moderate	Severe
o	Marital	Past/Current	Mild	Moderate	Severe
o	Family	Past/Current	Mild	Moderate	Severe
o	Job	Past/Current	Mild	Moderate	Severe
o	Losses/Deaths	Past/Current	Mild	Moderate	Severe

- Have you ever had thoughts of hurting yourself or someone else? Yes____ No_____
- Are you currently suicidal Yes_____ No_____ Are you currently homicidal? Yes_____ No_____
- If YES to either of the last 2 questions, please explain___________________________________
- ____

Trauma/Abuse:

Have you ever experienced a traumatic event? **YES______NO______**

Have you ever experienced an abusive event? **YES______NO______**

SYMPTOMS/MOOD/BEHAVIOR (please circle the answer that best applies to the past month)

1. Problems with eating	Rarely	Sometimes	Often	Always
2. Problems with sleep	Rarely	Sometimes	Often	Always
3. Physical pain	Rarely	Sometimes	Often	Always
4. Digestive problems	Rarely	Sometimes	Often	Always
5. Sadness	Rarely	Sometimes	Often	Always
6. Constantly worrying Anxiety/fears	Rarely	Sometimes	Often	Always
7. Difficulty with anger	Rarely	Sometimes	Often	Always

8. Have you ever been incarcerated? Yes______ No_____ If yes, year____________

What are your Strengths? ________________________ ________________________

What are your Weaknesses? ________________________ ________________________

THREE GOALS I WOULD LIKE TO ACHIEVE IN THERAPY:

1.____

2.____

3.____

____ ____________

Patient Signature Date