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ADULT HISTORY QUESTIONNAIRE

IDENTIFICATION

TODAY'S DATE: _____

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ GENDER: _____ AGE: _____

_____ CELL PHONE: _____

HIGHEST LEVEL OF EDUCATION: _____ RELIGION: _____

OCCUPATION: _____ CURRENTLY WORKING? □ No □ Yes

ETHNIC BACKGROUND: _____ STATUS: □ FT □ PT □ Other _____

CURRENT PROBLEM

1. Please briefly describe the major problem for which you are seeking help:_____
   _____
   _____
2. How long have you had this problem?_____
3. What other problems would you like help with?_____
   _____
   _____
4. Have you ever seen a counselor of any kind before? □ No □ Yes – When, and for what reason?____
   _____
   _____
5. What led you to seek help at this time?_____
   _____
6. What is the likelihood that you will achieve your goal?
   □ Not at all likely □ Slight possibility □ Good chance □ Probably □ Very likely
7. Who else knows that you have this problem? _____

PROBLEM CHECKLIST

Please check each of the items below that you have experienced recently:

□ difficulty concentrating	□ feel like harming myself	□ headaches	□ financial problems
□ confused thoughts	□ the future looks grim	□ chronic illness	□ family problems
□ disturbing thoughts	□ tire easily and often	□ chronic pain	□ relationship problems
□ seeing things that aren't there	□ difficulty sleeping	□ feel angry	□ work problems
□ hearing things	□ loss of appetite	□ feel violent	□ marital problems
□ trouble with memory	□ feel lonely	□ use of alcohol or drugs	□ eating disorder
□ distrustful of others	□ feel useless	□ poor social life	□ overweight
□ unreasonable fears	□ don't like myself	□ in trouble with the law	□ feel like I have no control
□ anxious and tense	□ can't get things done	□ act before thinking	□ self-harm/injurious behavior
□ panic attacks	□ people don't understand me	□ do not assert myself	□ addictive behavior
□ feel sad and blue	□ physical complaints	□ sexual issue	□ other: _____

HEALTH HISTORY

1. Who is your family doctor or primary care physician? _____
2. Please list any medications or supplements you are currently taking: _____
   _____
3. Please describe any current health problems that you have and treatment you are receiving:_____
   _____
   _____

4. Please list any serious illnesses/major injuries that you have had and the age at which they occurred:
   _____
   _____
   _____

5. Please list any hospitalizations that resulted from <u>medical</u> problems (age, reason): _____
   _____
   _____

6. Please list any hospitalizations that resulted from <u>emotional</u> problems (age, reason): _____
   _____
   _____

7. Do you have any allergies? □ No □ Yes – To what? _____
8. Do you smoke cigarettes? □ No □ Yes # per day ____ # of years: ____
   Do you want to stop? □ No □ Yes
9. Do you drink alcohol? □ No □ Yes # days/week: ____ # drinks/week: ____ # of years: ____
10. Do you use drugs? □ No □ Yes Which ones? _____
    How often? □ Experimental □ Occasionally □ Regularly
11. Do you struggle with any other addictive behavior (e.x. gambling, pornography, etc.)? □ No □ Yes
    If yes, which ones: _____
12. Were you ever a victim of any form of child abuse? □ No □ Yes
13. Have you ever been accused of any type of child abuse? □ No □ Yes

FAMILY HISTORY

1. Have any of your relatives suffered from any of the following?
   □ depression □ anxiety disorders □ eating disorders □ alcohol problems
   □ drug problems □ schizophrenia □ bipolar disorder □ chronic pain
   □ ADD/ADHD □ other: _____

2.

<u>Parents</u>:	Mother	Father	Stepmother	Stepfather
Age	_____	_____	_____	_____
Occupation	_____	_____	_____	_____
Education	_____	_____	_____	_____
Religion	_____	_____	_____	_____
Yr of death/cause	_____	_____	_____	_____
Current marital status	_____	_____	_____	_____

3. Siblings: # of brothers: _____ # of sisters: _____ Your birth order (i.e. 2nd of 4): _____
4. Children: Biological: _____
   Step: _____
   Adopted: _____

RELATIONSHIP HISTORY

1. Current marital status (check all that apply):
   □ single □ never married □ living together □ engaged □ married □ separated □ divorced □ widowed
2. Current partner:
   Name: _____ Age: _____ Ethnic Background: _____
   Religion: _____ Education: _____
   Occupation: _____ Employment Status: _____
3. Have you been previously married? □ No □ Yes # of times: _____
4. Children from previous relationship(s)? _____
5. Have you ever been the victim or perpetrator of domestic violence? □ No □ Yes

PERSONAL HISTORY

1. Have you ever been convicted of a crime? □ No □ Yes Please explain: _____
2. How do you spend your leisure time? _____
3. Please list any other pertinent information not previously asked: _____
   _____
   _____
   _____
   _____