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ADULT HISTORY QUESTIONNAIRE

Please bring this completed form to your initial appointment.
• If you need additional space for any of the questions, please use the back of the sheet. •

Client's Name:		Gender: ❑M ❑F	Birth Date:	Age:
Today's Date:			Email:	
Form Completed By (if other than client):			Home Phone:	
Address:			Work Phone:	
City:	State:	Zip:	Cell Phone:	
Primary Care Provider (PCP):			PCP Address:	Phone:
Clinic:				Fax:

Why are you coming to therapy now?

Have you recently had changes with:

❑ Anger	❑ Drug / Alcohol Use	❑ Sexual Activity
❑ Appetite	❑ Energy Level	❑ Sleep
❑ Anxiety / Worry	❑ Health Problems (specify):	❑ Suicidal Thoughts
❑ Concentration	❑ Homicidal Thoughts	❑ Weight
❑ Depression / Sadness	❑ Panic	❑ Other (specify):

Have you experienced any of the following in the past year?

❑ Bankruptcy / Financial Stress	❑ Family Member's Health Problems	❑ New Job
❑ Death of a Family Member	❑ Lost Job	❑ Started a New Romantic Relationship
❑ Death of a Friend	❑ Major Illness	❑ Surgery
❑ Ended a Romantic Relationship	❑ Moved	❑ Other (specify):

Do you have any physical or medical problems? If so, please list them below.

Problem	When Began / Stopped	Medications Prescribed	Amount	Prescribed by (Dr./Clinic)

Have you been in therapy in the past? If so, who did you see, and when? Do you feel you achieved positive results with the issues you were working to change? Was the therapy beneficial?

Have you ever been prescribed medication for mental health issues? If so, please list:

Medication	Dose	Dates Taken	Prescribed by (Dr./Clinic)	Results

Are you currently taking any prescription medications for your physical or mental health? If so, please list:

Prescription Medication	Dose	Date began taking	Prescribed by (Dr./Clinic)	Results

Are you currently taking any over-the-counter medications, aspirins, herbs, and/or vitamins? If so, please list:

Medication / Aspirin / Herb / Vitamin	Dates Taken	How Much & How Often / For What Problem?

Are you allergic to any medications?

❑Yes ❑No	If yes, describe:

Please list what you eat in a typical day.

Have you ever been diagnosed with an eating disorder? ❑Yes ❑No
If yes, specify:

Please check behaviors and symptoms that happen more often than you would like.

❑ Aggression to animals	❑ Elevated mood	❑ Lying
❑ Aggression to people	❑ Fatigue	❑ Memory problems
❑ Alcohol / Drug use	❑ Friendship problems	❑ Mood changes
❑ Anger	❑ Gambling	❑ Motivation low
❑ Antisocial behavior	❑ Grades inconsistent / low	❑ Nightmares / Night terrors
❑ Anxiety	❑ Guilt	❑ Panic attacks
❑ Arguing	❑ Hallucinations	❑ Phobias / Fears, of what:
❑ Avoiding people	❑ Headaches / Migraines	❑ Sexual addiction
❑ Caffeine use	❑ Heart palpitations	❑ Sexual difficulties
❑ Chest pain	❑ Hopelessness	❑ Sexual identity confusion
❑ Compulsions / Obsessions	❑ Homicidal thoughts	❑ Sick frequently
❑ Concentration problems	❑ Hyperactivity	❑ Skipping school / Missing work
❑ Conflict with peers / spouse / children	❑ Impulsivity	❑ Sleeping too much / too little
❑ Depression	❑ Internet addiction	❑ Speech problems
❑ Destruction of property	❑ Interrupts frequently	❑ Stealing
❑ Disorientation	❑ Irritability	❑ Stomach aches
❑ Disorganized thinking	❑ Job loss	❑ Suicidal thoughts
❑ Distractibility	❑ Judgment errors	❑ Withdrawing
❑ Dizziness	❑ Loneliness	❑ Work conflict
❑ Domestic Abuse	❑ Loses temper	❑ Worrying
❑ Eating too much / too little / throwing up	❑ Low self esteem	❑ Other (specify):

Which drugs have you used / are you currently using?

	Current / Past	Amount	Frequency	Age of First Use	Age of Last Use
Alcohol					
Barbiturates					
Caffeine					
Cocaine / Crack					
Ecstasy					
Heroin					
Inhalants					
Marijuana					
Nicotine (Tobacco products)					
PCP / LSD / Mescaline					
Valium					
Over-the-counter					
Prescription drugs					
Other (specify):					

Have you ever received a drunk driving ticket?	❑ Yes ❑ No	
Have you ever blacked out from drinking?	❑ Yes ❑ No	
Have you ever been treated for substance abuse?	❑ Yes ❑ No	
Has your substance abuse ever caused conflict with family/friends?	❑ Yes ❑ No	
Please provide more details if "Yes" was answered to any of the above:		

Have you ever attempted suicide/planned to hurt yourself? ❑Yes ❑No	Are you currently suicidal? ❑Yes ❑No
If yes, when?	Do you currently have thoughts of self-harm? ❑Yes ❑No
Have you ever engaged in self-mutilation? ❑Yes ❑No	Do you currently have plans to harm someone else? ❑Yes ❑No
If yes, when/how?	If yes, who?

Have you ever been hospitalized for psychiatric problems?

When / Where	Reason	Age

Have you ever been hospitalized for medical problems?

When / Where	Reason	Age

Have you ever been:		Age
Sexually abused	❑ Yes ❑ No	
Physically abused	❑ Yes ❑ No	
Neglected	❑ Yes ❑ No	

What is your marital status?

❑ Single	❑ Married	❑ Divorced
❑ Widowed	❑ Married in the past – Number of times:	

Who do you live with? (check all that apply)	Name(s):	Age(s):
❑ Alone		
❑ Significant other or spouse		
❑ Children		
❑ Parent(s)		
❑ Roommate(s)		
❑ Other (specify):		

Family of origin:	Name	Age	Living?
Mom			❑ Yes ❑ No
Dad			❑ Yes ❑ No
Siblings (list all)			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No

History of Physical & Mental Health Problems in Biological Family
(Parents, Grandparents, Siblings, Children, Aunts & Uncles, Cousins, Nieces, Nephews)

Name	Relation	When	Problems

Ethnicity & Religion

What is your cultural / ethnic background?
Do you consider yourself to be spiritual / religious? ❑ Yes ❑ No

Legal

Do you currently have, or have you ever had, legal problems? ❑ Yes ❑ No (if yes, please describe.)	
Date	Description

Education

	Where	Year(s)	Area(s) of study (if applicable)	Graduated
High School				❑Yes ❑No
G.E.D.				❑Yes ❑No
Technical School				❑Yes ❑No
College				❑Yes ❑No
Graduate School				❑Yes ❑No
Other Training				❑Yes ❑No

Are you currently employed?

❑ Full time	❑ Part Time	❑ Laid off	❑ Student	❑ Homemaker	❑ Retired	❑ No
Where do you work:			Title:		Length of employment:	

Military

Do you have any experience serving in the military? ❑ Yes ❑ No
Where?
When?
Were you involved in combat?
Date discharged:
Type of discharge:

What do you typically do for fun / hobbies?

How often do you socialize / go out with friends?

Are you having any problems with your children / stepchildren? (if applicable)

Are you having any difficulties in your current romantic relationship? (if applicable)

What do you wish to accomplish in the initial session?

What are your goals for therapy?

Please bring this form to your initial appointment.
Thank you!
-Luci