ADULT HISTORY QUESTIONAIRE

Your Name_____ Today's Date_____

Please circle the number that best represents your concern. Please do not skip sections. It is important that I get a complete history.

1 Not a Problem	2 A Mild Problem	3 A Moderate Problem	4 A Serious Problem

YOUR PHYSICAL FUNCTIONS		YOUR WORK EXPERIENCE	
Sleep too much	1 2 3 4	General Performance	1 2 3 4
Can't get to sleep or stay asleep	1 2 3 4	General Satisfaction	1 2 3 4
Appetite changed	1 2 3 4	Lateness	1 2 3 4
Weight Gain	1 2 3 4	Absenteeism	1 2 3 4
Weight Loss	1 2 3 4	Relating to Co-workers	1 2 3 4
Sexual Functioning	1 2 3 4	Negative feelings about work	1 2 3 4
Fatigue/Lack of Energy	1 2 3 4	Relating to your Supervisor	1 2 3 4
Speech (Stuttering or Stammering)	1 2 3 4	Relating to Supervisees	1 2 3 4
YOUR INNER THOUGHTS & IDEAS		PROBLEM AREAS	
Trouble Concentrating	1 2 3 4	Problems with Raising Children	1 2 3 4
Memory Problems	1 2 3 4	Dealing with someone else's alcohol\drug use	1 2 3 4
Thoughts of Hurting Self	1 2 3 4	Death of a loved one	1 2 3 4
Thoughts of Hurting Others	1 2 3 4	History of Sexual Abuse	1 2 3 4
Excessive Worries	1 2 3 4	Having health problems	1 2 3 4
Worried about Gaining too much weight	1 2 3 4	Family Violence (actual or threatened)	1 2 3 4
Thinking about something over and over (Obsession)	1 2 3 4	Relating to Your Spouse or Partner	1 2 3 4
Phobias	1 2 3 4	History of Physical Abuse	1 2 3 4
Worry About Your Health	1 2 3 4	Handling Financial Problems	1 2 3 4
Experiencing Confusion	1 2 3 4	Handling Legal Problems	1 2 3 4
		Dealing With Aging Parents	1 2 3 4
YOUR FEELINGS AND MOODS			
Depressed/Sad a lot	1 2 3 4	YOUR BEHAVIOR	
Frequent Crying	1 2 3 4	Lying	1 2 3 4
Feeling Angry Often	1 2 3 4	Letting others take advantage of you	1 2 3 4
Irritability	1 2 3 4	Violent toward others	1 2 3 4
Doesn't Like Self	1 2 3 4	Keep to your self most of the time	1 2 3 4
Sudden Change in Moods	1 2 3 4	Attempted to hurt self	1 2 3 4
Anxiety/nervousness	1 2 3 4	Difficulty with Daily Routine	1 2 3 4
Becomes easily Frustrated	1 2 3 4	Do not have friends who are supportive	1 2 3 4
Feels Lonely	1 2 3 4	Using alcohol\drugs to cope with problems	1 2 3 4
No longer enjoy things you used to enjoy	1 2 3 4	Suicidal Actions	1 2 3 4
Hopelessness	1 2 3 4	Repeating certain acts over and over again	1 2 3 4
Euphoria (feeling "high", lots of energy)	1 2 3 4	Hyperactivity (can't sit still)	1 2 3 4
Worthlessness	1 2 3 4	Stealing	1 2 3 4
Lack of Energy	1 2 3 4	Dependency (relying on others to make your decisions)	1 2 3 4

What is the primary problem that has brought you to counseling?

Please list goals you hope to achieve in counseling. (Be Specific) _____

_____

_____

Have you been in therapy before? _____ When? _____ Was it helpful? _____

Names of Prior Mental Health\Chemical Dependency Providers: _____

_____

Current Medications	Dosages	Started When?	For What Condition?	Prescribed By?

Primary Physician's Name: _____Practice Name: _____Phone #: _____

Are you currently under the care of a physician and for what: _____

Last Exam? _____ Please list additional medical conditions, past and present: _____

Have you ever had or have seizures or have diabetes's? _____Please list any supplements, vitamins or other non-prescription aids you are taking_____

Have you ever had a head injury (either losing or not losing consciousness)? _____

Religious Affiliation: _____

Religion's importance to you: □ Not at all □ Some what □ Very

List any family history of Mental Health and Chemical Dependency: _____

_____

How many years of education do you have? _____ Highest degree earned? _____

How many times have you been married? _____ Divorced? _____ Are you currently separated? _____

SUBSTANCE USE HISTORY	Amount used and frequency IN THE LAST MONTH Example: 3 beers per day (now)	None	Amount used, frequency and dates WHEN YOU USED IT THE MOST Example: ^ BEERS PER DAY IN 1991	None
Coffee-tea-caffeinated soda				
Cigarettes				
Alcohol				
Marijuana				
Cocaine				
Amphetamines (uppers)				
Barbiturates (downers)				
Tranquilizers				
Hallucinogens				
Opiates				
Other				

Do you have any established routines that you do regularly (i.e. exercise, reading, church attendance etc)?_____

_____

What are your hobbies and interests? _____

_____

Your Social Support system includes: _____

_____

Do you think your support system works for you? _____

Please provide any other information you think is important_____

THANK YOU FOR BEING THOROUGH!