Confidential Adult Questionnaire

Client's Full Name _____ Date _____

Please complete this form to help your clinician as he/she talks with you regarding your problems. If you are unsure about the answers to any of these questions, please discuss them with your clinician.

Form completed by: ☐ Self ☐ Family Member | Caregiver
☐ Other_____

Current Concerns: What are the main reasons for which you are seeking help?

	Major issues	Important issues	Not an issue
Personal/Emotional issues	☐	☐	☐
Relationship/Marriage	☐	☐	☐
Sexual concerns	☐	☐	☐
Job/Vocational	☐	☐	☐
Health issues	☐	☐	☐
Financial issues	☐	☐	☐
Stress	☐	☐	☐

Other _____

How long has this been a concern to you? _____

What efforts have you made to deal with this concern(s)? _____
_____
_____

What ideas do you have about how this developed? _____
_____
_____

What important things have happened to you or your family in the last six months?
_____
_____

Current Living Situation

Marital/Relationship Status:

☐ Single
☐ Married/Permanent partner (how long?_____)
☐ Living with a partner (how long?_____)
☐ Widowed (how long_____)
☐ Separated (how long? _____)
☐ Divorced (how long? _____)
☐ Previous marriage Relationship (how long?_____)
1 2 3 4 5+ (how long?_____)

Names of Persons living in the household	***Age***	***Relationship to patient***	***Gender***
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____

Immediate family elsewhere: _____

Marital/Relationship History

	No	Yes
Partner/spouse has current illness/physical problem?	☐	☐
Generally satisfied with current relationship?	☐	☐
Satisfied with sex life?	☐	☐
Current or past violence in this relationship?	☐	☐
Crisis or trauma during this relationship?	☐	☐

If yes, describe:_____

_____

What do you most enjoy about your relationship?_____

_____

Least enjoy?:_____

Medical/Lifestyle History

Name of Primary Care Physician _____

Address _____

City_____ State_____ Zip_____

Telephone _____

Most Recent Medical Examination: Month_____ Year_____

Current Health ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Current illnesses or chronic conditions ☐ No ☐ Yes

Migraines	☐ Yes	☐ No	If yes, onset	_____
Allergies	☐ Yes	☐ No	If yes, to what	_____
Head Injury	☐ Yes	☐ No	If yes, date	_____
Seizure disorder	☐ Yes	☐ No	If yes, date	_____

Please list other illnesses/chronic conditions (including major childhood illness)

Illness	Dates	Medication/Dose	Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medication(s) currently used (other than those described above):

Medication/Dose	Date Prescribed	Why Prescribed	Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Reproductive History:

Number of Pregnancies: _____

Number of live births: _____

Currently pregnant: ☐ Yes ☐ No ☐ Maybe

Past Hospitalizations (Medical/Psychiatric/Chemical/Dependency)

Date	Reasons	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

Alcohol

How often do you use alcohol? ☐ None ☐ Monthly ☐ Weekly ☐ Daily

On the days that you drink, how many drinks do you have?

☐ 2 or less ☐ 3 to 5 ☐ more than 5

Do you consider it a problem? ☐ No ☐ Yes

Do others consider it a problem? ☐ No ☐ Yes

Have you had problems with alcohol in the past? ☐ No ☐ Yes

Nicotine

Do you smoke or use tobacco now? ☐ No ☐ Yes

How much?_____ How long?_____

Have you smoked or used tobacco in the past? ☐ No ☐ Yes

How much?_____ How long?_____

Caffeine

How many caffeinated coffee/tea servings do you drink a day?_____ Cups or mugs? _____

How many caffeinated soft drinks?_____ Size? _____

How much chocolate/cocoa? _____ Size? _____

Drug use

Marijuana: ☐ None ☐ Occasionally ☐ Weekly ☐ Daily

Do you use other non-prescription substances?

If yes, what substance?_____

How often? ☐ Occasionally ☐ Weekly ☐ Daily

Exercise

How many times a week do you exercise?

How long? ☐ 15 minutes ☐ 30 mins. ☐ 45 mins. ☐ An hour or more

What do you do for exercise?_____

Weight

Do you consider yourself: ☐ At a healthy weight ☐ Overweight _____ lbs. ☐ Underweight _____ lbs.

Have you had a weight gain over the last year?

☐ No ☐ Yes How much?_____

Have you had a weight loss over the last year?

☐ No ☐ Yes How much?_____

Mental Health

Is there a family history of (check all that apply)

☐ Alcoholism ☐ Substance Abuse ☐ Mental Illness ☐ Suicide

Name	Relationship	Problem
_____	_____	_____
_____	_____	_____
_____	_____	_____

Childhood History

As a child did you have any problems with:

			Age
☐ Learning disabilities	☐ No	☐ Yes	_____
☐ Hyperactivity	☐ No	☐ Yes	_____
☐ Bed Wetting	☐ No	☐ Yes	_____
☐ School fears	☐ No	☐ Yes	_____
☐ Depression	☐ No	☐ Yes	_____
☐ Sexual or physical abuse	☐ No	☐ Yes	_____

Did you have any other major childhood (0-17 years) school, learning, or emotional problems?

☐ No ☐ Yes If so, please describe:_____

_____

Have you ever taken work leave for mental health/chemical dependency problems?

☐ No ☐ Yes How long?_____

Have you experienced significant Life Trauma (s)or fearful/distressful experience (including losses):

What	Dates
_____	_____
_____	_____
_____	_____

Suicide

Have you attempted suicide?	☐ No	☐ Yes
Do you currently have suicidal thoughts?	☐ No	☐ Yes

Previous Counseling, EAP, or Chemical Dependency Services:

Have you ever seen anyone or are you currently seeing anyone for:

Individual Therapy	☐ No	☐ Yes	Marital/Couples Therapy	☐ No	☐ Yes
Group Psychotherapy	☐ No	☐ Yes	Sex Therapy	☐ No	☐ Yes

If Yes, please list:

Facility/Counselor Name	Dates Seen	Reason Seen	Helpful	
_____	_____	_____	☐ No	☐ Yes
_____	_____	_____	☐ No	☐ Yes
_____	_____	_____	☐ No	☐ Yes

Social contacts

Do you see people regularly/weekly that you consider good friends?	☐ No	☐ Yes
Do you have friends or family who you talk to when you have concerns or problems?	☐ No	☐ Yes
Do you participate in regular social activities?	☐ No	☐ Yes
Do you participate in a religious group?	☐ No	☐ Yes
Do you have any pets? Type/names: _____	☐ No	☐ Yes

Family History

Mother's age_____ If deceased, how old were you when she died? _____
Father's age_____ If deceased, how old were you when he died? _____
Number of brother(s) _____ Their ages and first names _____
Number of sister (s) _____ Their ages and first names _____
I was child number _____ in a family of _____children
Were you adopted or raised with parents other than your natural parents? ☐ Yes ☐ No

Which of the following best describes the family in which you grew up?

Warm and Accepting			Average			Distant, Hostile and Fighting		
1	2	3	4	5	6	7	8	9

Was the family home disrupted by separation/divorce/serious illness/accident/death?
☐ No ☐ Yes If yes, please identify the ones that apply and state how old you were for each?
_____
_____
_____
List other major family problems_____
_____
_____
_____

My Work History

Employment status:
☐ Employed, Full-time
☐ Employed, part-time
☐ Self Employed
☐ Other
☐ Unemployed
☐ Student
☐ Home maker
(specify)_____

Job satisfaction: ☐ Very satisfied ☐ Fairly Satisfied ☐ Not at all satisfied
What type of problems do you have with people, or with the type of work at your present or last job or position?_____
_____
_____
_____
_____
Is there any other information about yourself you feel might be important for your clinician to know?.
_____
_____
_____
_____

Contact Information

Name _____ SSN _____
Address _____
City _____ State _____ ZIP _____
Home Phone _____ Work Phone _____ Mobile/Pager _____
Date of Birth _____ Gender ☐ Male ☐ Female

If Child/Student: Parent/Guardian's Name _____
Relationship to Child _____ Phone _____
School Currently Attending _____ Grade/Year _____

If Adult:
Name of Employer _____ Occupation _____
Spouse/Partner's Name _____

In Case of Emergency notify:
Name _____ Relationship_____
Address _____
City _____ State _____ ZIP _____
Home Phone _____ Work Phone _____ Mobile/Pager _____

Billing Information: Person Responsible for Payments
Name _____ Relationship_____
Address _____
City _____ State _____ ZIP _____
Home Phone _____ Work Phone _____ Mobile/Pager _____
Employer _____ City _____ State ____ ZIP _____

Referral Source: How did you find out about Dr. Bob?

- ☐ Phone Book
- ☐ Radio Ads
- ☐ Friend
- ☐ HMO or Insurance Co.
- ☐ EAP
- ☐ Employer
- ☐ Health Care Professional
- ☐ Therapist
- ☐ Attorney
- ☐ Website
- ☐ Brochure
- ☐ Other

If the referral came from an individual:
May I thank them and let them know you are working with me? ☐ Yes ☐ No
Name _____
Employer or Organization (if appropriate) _____

Thank you.

Contact Information (Cont.)

Email_____