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ADULT INTAKE/HISTORY QUESTIONNAIRE

Please complete this questionnaire to the best of your ability. Your history and background are important to understanding where you are today. There may be information that you do not know or have access to at this time. All information will be kept confidential.

PATIENT IDENTIFICATION:

Name:________________________________**Sex**: M F **Birth Date**:__/__/__**Today's Date**:__/__/__
Address:__________________________________**City**:_________________**St**:_____**Zip**:__________
Home phone:_(_____)___________**Cell**:_(_____)____________**Work**:_(____)________________
Marital Status: ________**Who resides in your home**?_____________________________________
Employment:______________________________**Job Title**:___________________________________
Who referred you here?_______________________________ **Phone:**_________________________
Primary Care Physician:________________________ **Phone**:___________**Fax**:________________
Address:______________________________**City**:___________________**St**:_______**Zip**:___________
Last time seen:________________ **Date of Last Complete Physical**:__________________________

REASON FOR CURRENT APPOINTMENT: ____
____
____

PREVIOUS PSYCHOLOGICAL/PSYCHIATRIC TREATMENT

PROFESSIONAL	DATES OF TREATMENT	DIAGNOSIS/REASON FOR VISIT

CURRENT MEDICATIONS

Please include supplements / vitamins

Medication and Dosage	Prescribed for	Physician	Response to Medication

HISTORY OF MEDICATIONS - PSYCHIATRIC

Medication	Prescribed for	Physician	Response to Medication

Are you allergic to any medications? If so, please list:_______________________________________

MEDICAL HISTORY

Current medical problems:____

____

Please complete the following medical history on yourself:

AREA	Past Problem	Current Problem	If yes, please provide additional information
Head trauma	Yes ❒ No ❒	Yes ❒ No ❒	
Seizures	Yes ❒ No ❒	Yes ❒ No ❒	
Hearing problems	Yes ❒ No ❒	Yes ❒ No ❒	
Vision problems	Yes ❒ No ❒	Yes ❒ No ❒	
Asthma	Yes ❒ No ❒	Yes ❒ No ❒	
Allergies	Yes ❒ No ❒	Yes ❒ No ❒	
Diabetes	Yes ❒ No ❒	Yes ❒ No ❒	
High Blood Pressure	Yes ❒ No ❒	Yes ❒ No ❒	
Heart problems	Yes ❒ No ❒	Yes ❒ No ❒	
Cancer	Yes ❒ No ❒	Yes ❒ No ❒	
Surgery	Yes ❒ No ❒	Yes ❒ No ❒	
Stomach problems	Yes ❒ No ❒	Yes ❒ No ❒	
Sleep problems	Yes ❒ No ❒	Yes ❒ No ❒	
History of sexual abuse	Yes ❒ No ❒	Yes ❒ No ❒	
History of physical abuse	Yes ❒ No ❒	Yes ❒ No ❒	
History of other trauma	Yes ❒ No ❒	Yes ❒ No ❒	
Gynecological problems	Yes ❒ No ❒	Yes ❒ No ❒	
Depression	Yes ❒ No ❒	Yes ❒ No ❒	
Anxiety	Yes ❒ No ❒	Yes ❒ No ❒	
Bipolar Disorder	Yes ❒ No ❒	Yes ❒ No ❒	
Obsessive-Compulsive	Yes ❒ No ❒	Yes ❒ No ❒	
Tics/Tourettes	Yes ❒ No ❒	Yes ❒ No ❒	

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Medical History [CONTINUED]

AREA AREA	Past Issue	Current Problem	If yes, please provide additional information
Thyroid	Yes ❒ No ❒	Yes ❒ No ❒	
Neurological problems	Yes ❒ No ❒	Yes ❒ No ❒	
Alcohol abuse	Yes ❒ No ❒	Yes ❒ No ❒	
Drug abuse	Yes ❒ No ❒	Yes ❒ No ❒	
ADHD	Yes ❒ No ❒	Yes ❒ No ❒	
Hospitalizations	Yes ❒ No ❒	Yes ❒ No ❒	
Other:	Yes ❒ No ❒	Yes ❒ No ❒	
Other:	Yes ❒ No ❒	Yes ❒ No ❒	
Other:	Yes ❒ No ❒	Yes ❒ No ❒	

ALCOHOL AND/OR DRUG HISTORY

Your use of alcohol and/or drugs is an important part of your history. Please list age started, types of substances used, and current usage. Substances include, but not limited to: alcohol, marijuana, hash, prescription medications abused, inhalants, cocaine, crack, amphetamines, crank, steroids, heroin, morphine, barbiturates, LSD, mescaline, mushrooms, PCP, ecstasy, ketamines and any others.

Substance	Age Started	How long? (mos, yrs)	Current ?
			Yes ❒ No ❒
			Yes ❒ No ❒
			Yes ❒ No ❒
			Yes ❒ No ❒
			Yes ❒ No ❒
			Yes ❒ No ❒
			Yes ❒ No ❒
			Yes ❒ No ❒
			Yes ❒ No ❒

History of treatment for substance abuse: In-patient, out-patient, AA and/or NA: ________________
____
____

Has anyone ever told you they thought you had a problem with drugs or alcohol? Yes ❒ No ❒

Have you ever thought you had an alcohol or drug problem? Yes ❒ No ❒

Have you ever tried to cut back or quit unsuccessfully? Yes ❒ No ❒

Have you ever experienced blackouts (memory loss) after using alcohol/drugs? Yes ❒ No ❒

Have you ever used alcohol or drugs first thing in the morning? Yes ❒ No ❒

Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate):_________________________________

Nicotine use per day, past and present:____

Cigarettes ❒ Chewing Tobacco ❒ Other ❒ ______________________________________

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FAMILY HISTORY

Spouse / Significant Other Name: ________________________________ Age: _________

Current issues in this relationship (separation, pending divorce, abuse, etc.): _______________________
____

CHILDREN

Name	Age	Sex	Current residence	Biological/Adopted/Step-child

Do you have a history of past marriages? Yes ❐ No ❐ If Yes, please describe:____________________
____

FAMILY OF ORIGIN

Biological Mother

Name:____ Living Deceased

If living, current place of residence:____Age:_____

Highest grade completed in school:_______Learning problems:______________________________

Marriages:____

History of alcohol/drug use:____

History of psychiatric treatment:____

Biological Father

Name:____ Living Deceased

If living, current place of residence:____Age:_____

Highest grade completed in school:_______Learning problems:______________________________

Marriages:____

History of alcohol/drug use:____

History of psychiatric treatment:____

Other Parents / Significant Others

Step-parents: ____
____

Other Guardians: ____
____

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BROTHERS AND SISTERS

Name	Age	Sex	Biological/Adopted/Step/Half	Describe relationship

History of alcohol/drug abuse by brother/sister(s): Yes ❒ No ❒ If Yes, please give details: _________

____

History of depression, anxiety, ADHD, learning problems, suicide attempts, psychiatric hospitalizations of brother/sister(s): Yes ❒ No ❒ If Yes, please give details: ___________________________________

____

SOCIAL LIFE

What social activities are you currently involved in (clubs, sports, etc.): ___________________________

____

Who are your closest friends? ____

Do you have difficulty making or keeping friends? Yes ❒ No ❒

Did you have a best friend growing up? Yes ❒ No ❒

Do you have a best friend now? Yes ❒ No ❒

Do you prefer small groups of friends or large groups of friends?________________________________

SPIRITUAL

Do you attend church or temple on a regular basis? Yes ❒ No ❒

If yes, where do you attend?____

What activities, other than worship service, are you involved in at your church or temple?______________

____

Do you have any particular issues or concerns related to your spiritual life? _________________________

____

How important is your religious/spiritual faith and practice to you? (Check One)

Extremely ❒ Very ❒ Somewhat ❒ Not Very ❒ Not At All ❒

Did you and your family attend church or temple when you were a child? Yes ❒ No ❒

If yes, where did you attend as a child? ____

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EMPLOYMENT HISTORY

List the jobs you've had since age 18. Indicate which jobs you liked and which ones you did not. Also, describe any work-related problems that you have experienced:

Age	Place of Employment	Responsibilities	How long?	Did you enjoy job?
				Yes ❒ No ❒
				Yes ❒ No ❒
				Yes ❒ No ❒
				Yes ❒ No ❒
				Yes ❒ No ❒
				Yes ❒ No ❒
				Yes ❒ No ❒
				Yes ❒ No ❒
				Yes ❒ No ❒
				Yes ❒ No ❒
				Yes ❒ No ❒

What would your employers or supervisors say about you?______________________________________

____

MILITARY HISTORY: Branch:_____________Years:________Final Rank:___________________

Discharged?: Yes ❒ No ❒ Type:____________Service Connected Disabilities:_______________

____

EDUCATIONAL HISTORY

Completed High School: Yes ❒ No ❒ If not, highest grade completed:______ GED: Yes ❒ No ❒

Average Grades in school:__________Best subject:____________Worst subject:_________________

Did you repeat a grade? Yes ❒ No ❒ If yes, which grade and why?___________________________

Were you ever in resource classes for any subject? Yes ❒ No ❒ If yes, which subject(s)?_________

____

Did you attend college? Yes ❒ No ❒ If yes, where?_______________________________________

Did you complete college? Yes ❒ No ❒ What is your degree in?_____________________________

Did you attend graduate school? Yes ❒ No ❒ If yes, did you complete the program? Yes ❒ No ❒

Comments:____

Are you currently in school? Yes ❒ No ❒ If yes, where? ___________________________________

Did you have any specific academic or behavioral problems that you recall in elementary, middle, or high school? Yes ❒ No ❒ If yes, please give as much detail as you can recall: __________________

____

If you are currently a student, please share any current problems/difficulties that you are experiencing in academic environment: ____

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Have you ever had any testing done either as a child or an adult due to academic problems? Yes ❒ No ❒

If yes, when were you tested and what were the results? ____

____

Other academic information that you feel is important to share: __________________________________

____

____

Please check any of the following areas that you have had or are currently having problems in:

AREA	Past Problem	Current Problem	COMMENTS
Attention/Concentration	Yes ❒ No ❒	Yes ❒ No ❒	
Staying focused	Yes ❒ No ❒	Yes ❒ No ❒	
Easily distracted	Yes ❒ No ❒	Yes ❒ No ❒	
Difficulty taking notes (orally given)	Yes ❒ No ❒	Yes ❒ No ❒	
Difficulty copying notes from board or overhead	Yes ❒ No ❒	Yes ❒ No ❒	
Completing homework	Yes ❒ No ❒	Yes ❒ No ❒	
Losing homework	Yes ❒ No ❒	Yes ❒ No ❒	
Disorganization	Yes ❒ No ❒	Yes ❒ No ❒	
Forgetful	Yes ❒ No ❒	Yes ❒ No ❒	
Daydreaming	Yes ❒ No ❒	Yes ❒ No ❒	
Completing tasks	Yes ❒ No ❒	Yes ❒ No ❒	
Time management	Yes ❒ No ❒	Yes ❒ No ❒	
Losing keys, etc.	Yes ❒ No ❒	Yes ❒ No ❒	
Several projects going at one time	Yes ❒ No ❒	Yes ❒ No ❒	
Difficulty completing paperwork	Yes ❒ No ❒	Yes ❒ No ❒	
Restless or fidgety	Yes ❒ No ❒	Yes ❒ No ❒	
Difficulty staying “tuned in” during meetings	Yes ❒ No ❒	Yes ❒ No ❒	
Impulsive behaviors	Yes ❒ No ❒	Yes ❒ No ❒	
Blurting out	Yes ❒ No ❒	Yes ❒ No ❒	
Frequent job changes	Yes ❒ No ❒	Yes ❒ No ❒	
Easily overwhelmed by daily living tasks	Yes ❒ No ❒	Yes ❒ No ❒	
Piles of things in your house	Yes ❒ No ❒	Yes ❒ No ❒	
Procrastination	Yes ❒ No ❒	Yes ❒ No ❒	
Difficulty staying engaged in a conversation	Yes ❒ No ❒	Yes ❒ No ❒	
Excessive worrying	Yes ❒ No ❒	Yes ❒ No ❒	
Search for high stimulation activities	Yes ❒ No ❒	Yes ❒ No ❒	
Difficulty with reading	Yes ❒ No ❒	Yes ❒ No ❒	
Difficulty with math	Yes ❒ No ❒	Yes ❒ No ❒	
Difficulty with spelling	Yes ❒ No ❒	Yes ❒ No ❒	
Problems with communication	Yes ❒ No ❒	Yes ❒ No ❒	
Difficulties with co-workers	Yes ❒ No ❒	Yes ❒ No ❒	
Other:	Yes ❒ No ❒	Yes ❒ No ❒	
Other:	Yes ❒ No ❒	Yes ❒ No ❒	

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FAMILY MEDICAL HISTORY

Please check all that apply

AREA	Mom	Dad	Brothers / Sisters	Mother's Family	Father's Family
Alcohol Abuse					
Drug Abuse					
Depression					
Bipolar Disorder					
Obsessive-Compulsive					
Anxiety					
ADHD					
Learning Difficulties					
Behavioral Problems					
Dyslexia					
Neurological Problems					
Seizure Disorder					
Tics/Tourettes					
Heart disease					
High Blood Pressure					
Diabetes					
Cancer					
Thyroid problems					
Allergies					
Other:					
Other:					
Other:					
Other:					
Other:					

SEXUAL HISTORY: (answer only as much as you feel comfortable)

Age at the time of first sexual experience:______Number of sexual partners:__________

Any history of sexually transmitted disease?____

History of abortion?______________________History of miscarriages?______________________

History of sexual abuse, molestation, or rape?____

____

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What would you like to accomplish in therapy?

1.____
2.____
3.____
4.____

Describe your strengths:

____
____
____

Describe your weaknesses:

____
____
____

Risk Assessment: Has there ever been, or is there currently, any evidence of the following:
Sexual/Physical Abuse ☐ Violence ☐ Suicidal Behavior ☐ Homicidal Behavior ☐ Substance Abuse ☐
Do you have Firearms in the Home: Yes ☐ No ☐ If yes, do you have a safety plan: Yes ☐ No ☐

Any other comments: ____
____
____
____
____

____ ____________________
Your signature **Date**

____ ____________________
Clinician's signature **Date**

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