

ADULT HISTORY QUESTIONNAIRE

Name: _____

Date of Birth: _____ Age: _____ Date: _____

I. PRESENTING PROBLEM:

Describe the problems you are having and when they started:

II. TREATMENT HISTORY

Describe any treatment you have had in the past. Please include the name of the provider, dates and any other relevant comments.

Do you have a psychiatric advanced directive? (circle) Yes No
If yes, explain and provide documentation:

III. ENVIRONMENTAL/ HOME/SUPPORTS/RESOURCES

Family:

Spouse/Significant Other: ___ Supportive ___ Problem _____

In-laws: ___ Supportive ___ Problem _____

Children: ___ Supportive ___ Problem _____

Children's Relationship to each other: ___ Supportive ___ Problem _____

Mother: ___ Supportive ___ Problem _____

Father: ___ Supportive ___ Problem _____

Siblings: ___ Supportive ___ Problem _____

Client Name: _____

DOB: _____

Additional information:

Social Environment:

Friends: ___ Supportive ___ Problem _____

Neighbors: ___ Supportive ___ Problem _____

Community: ___ Supportive ___ Problem _____

Religious Affiliation: ___ Supportive ___ Problem _____

Additional Information:

Education

___ Resource ___ Problem

Highest Grade Level Completed _____

Additional Information:

Occupation

Current Employment _____ Length of Time _____

___ Resource ___ Problem _____

Past Employment _____ Length of Time _____

___ Resource ___ Problem _____

Additional Information:

Housing

Current Living Situation _____

___ Resource ___ Problem _____

Additional Information:

Financial

Current Financial Situation _____

___ Resource ___ Problem _____

Additional Information:

Client Name: _____

DOB: _____

Legal

Current Legal Situation (include all arrests and any pending court action):

Past Legal Involvement

IV. MEDICAL HISTORY

PCP Name: _____ Phone: _____

Date of Last Examination: _____ Allergies: _____

Are you currently under treatment for any medical conditions? ___ No ___ Yes

If yes describe below:

* Completed Medical History Form _____

* Completed Medication Log _____

V. SUBSTANCE OR ALCOHOL USE/ABUSE

Alcohol/Drug Use History

| Substance | Frequency/Amount | First Use | Last Use |
|-----------|------------------|-----------|----------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Describe any problems you have experienced from using drugs/alcohol:

Client Name: _____

DOB: _____

Substance Abuse Treatment History

Previous Substance Abuse Treatment: ___ No ___ Yes

| <u>Location</u> | <u>Duration</u> | <u>Dates of Treatment</u> | <u>Reason for Admission</u> |
|-----------------|-----------------|---------------------------|-----------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**VI. SIGNIFICANT PSYCHOSOCIAL/DEVELOPMENTAL HISTORY
(Include any abuse)**

Childhood/Adolescence (illness, raised by, moving, school, relationships, developmental milestones)

Adulthood (relationships, job history, significant events)

Mature Years (retirement, goals, adjustments, losses, medical problems, relationships)

Client Name: _____
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DOB: _____

VII. FAMILY MENTAL HEALTH/ALCOHOL AND DRUG HISTORY
Describe any other family members that have received treatment and why:

VIII. FAMILY MEDICAL HISTORY
Describe any family medical problems:

IX. STRENGTHS/WEAKNESSES
Describe two strengths and two weaknesses:

Please write any other information you think your therapist should know about you.

What are your personal treatment goals?

Clinician Signature: _____ **Date:** _____

Client Name: _____ **DOB:** _____
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