ADULT HISTORY QUESTIONAIRE

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 _____
_____

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:
Legal

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

Past Legal Involvement

Leisure interests: _____

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:

How many hours of sleep do you typically get each night? _____ If you have sleep problems, please describe _____

Do you exercise? Y N If so what kind and how often _____

Are you concerned over eating habits? Y N If yes, please explain_____

Have you been hurt or threatened in the past year? Y N If yes, explain: _____

* Completed Medical History Form _____
* Completed Medication Log _____

V. SUBSTANCE OR ALCOHOL USE/ABUSE

Alcohol/Drug Use History

Substance	Frequency/Amount	First Use	Last Use

Are you interested in decreasing your consumption of:

Alcohol Y N Cigarettes Y N Caffeine Y N Explain: _____

Do you drink caffeine drinks? Y N If yes, how often and how much? _____
_____

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

Substance Abuse Treatment History
Previous Substance Abuse Treatment: ___No ___Yes

Location	Duration	Dates of Treatment	Reason for Admission

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)

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: _____