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ADULT INFORMATIONAL QUESTIONNAIRE

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Birth date: _____ Gender: ☐ F ☐ M

Grade/Ed. Level: _____ Relationship Status: _____

Phone: Please feel free to note if you prefer I not use one of the numbers listed.

Home:_____ May I leave message? ☐ Y ☐ N

Cell: _____ May I leave message? ☐ Y ☐ N

Work: _____ May I leave message? ☐ Y ☐ N

Emergency Contact (preferably someone not living with you): _____

_____

Current Problem

Describe the difficulties you are currently facing:

How long they have been going on:

What have you tried in the past to resolve your problem(s):

Psychological

Describe any past therapy experiences (include dates). What worked or didn't work?

Please select any of the following that you have experienced in the past 6 months:

Have you ever been psychiatrically hospitalized? (If, "yes," where and when?):	☐ Yes	☐ No
Has there been any history of abuse (physical, sexual, emotional)?	☐ Yes	☐ No
Is there any history of domestic violence in the home?	☐ Yes	☐ No
Has there been any history of suicidal ideation?	☐ Yes	☐ No
Has there been any previous suicidal attempts?	☐ Yes	☐ No
Has there been any history of aggressive behaviors toward others?	☐ Yes	☐ No

Please select any of the following that you have experienced in the past 6 months:

- ☐ Increased/decreased appetite
- ☐ Repetitive behavior
- ☐ Feeling empty
- ☐ Extreme worry
- ☐ Increased fears
- ☐ Flashbacks
- ☐ Lack of energy/lethargy
- ☐ Sleep problems
- ☐ Loss of interest
- ☐ Too much energy
- ☐ Short attention span
- ☐ Trouble concentrating
- ☐ Recurring thoughts
- ☐ Crying spells Increased anger
- ☐ Sexual issues
- ☐ Nightmares
- ☐ Abuse of alcohol/drugs
- ☐ Memory problems
- ☐ Feeling paranoid
- ☐ Racing thoughts
- ☐ Increased irritability
- ☐ Mood swings
- ☐ Nervousness
- ☐ Violent actions
- ☐ Isolation from others
- ☐ Relationship issues
- ☐ Panic attacks
- ☐ Hopelessness
- ☐ Change in weight
- ☐ Increased fears
- ☐ Easily frustrated
- ☐ Feeling stressed
- ☐ Low self-esteem
- ☐ Depressed mood
- ☐ Anxiety
- ☐ Unusual/extreme euphoria
- ☐ Increased fatigue
- ☐ Recklessness
- ☐ Self-hate
- ☐ Procrastination
- ☐ Confusion
- ☐ Hearing voices that others don't
- ☐ Seeing things others don't
- ☐ Disorientation

Other:

Please indicate whether there are any relatives including parents, siblings, grandparents, aunts, uncles and cousins who have the same or a similar problem for which you are seeking evaluation. Also indicate for these persons whether there are serious, chronic or recurrent illnesses. (Please be as specific as possible, giving relationship to child, age and problem).

Mother's Family:

Father's Family:

Medication

Please list any medications that you are currently taking and describe why you are taking them:

Therapy

What do you hope to get out of our work together?