



Confidential Adult History Questionnaire

Name:	Today's Date:
Primary Care Physician:	Present Occupation:
Date of Birth:	How Long:
Place of Birth:	Highest Grade or Education:

1. My main reason for seeking treatment is _____

2. How long has the problem existed? _____

3. The problem would improve if _____

4. Please list all past psychiatric counseling, self help, treatment experiences (including hospitalizations):

Facility or Town	Approximate Dates	Was it beneficial?
		<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> mixed
		<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> mixed
		<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> mixed

5. What medications are you currently taking?

Medication	Dosage	Frequency	Start Date	Prescribing Doctor

6. Are you having thoughts of wanting to harm yourself? yes no
 If yes, intensity of thoughts is: mild moderate severe
 If yes, Do you have a plan or intend to harm your self? yes no
 Have you ever attempted suicide? yes no
 If yes, when?: _____

7. Have you ever been a victim of: physical abuse sexual abuse emotional abuse

8. Are you in a relationship in which you have been hurt or threatened? yes no

9. Please check any of the following conditions that have applied to you over the past 6 months:

- | | | |
|---|--|--|
| <input type="checkbox"/> Delay in falling asleep | <input type="checkbox"/> Feelings of guilt | <input type="checkbox"/> Rapid heart beat |
| <input type="checkbox"/> Awakening during the night | <input type="checkbox"/> Crying spells | <input type="checkbox"/> Digestive problems |
| <input type="checkbox"/> Oversleeping | <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> Feeling tense |
| <input type="checkbox"/> Loss of energy | <input type="checkbox"/> Wishing to be dead | <input type="checkbox"/> Homicidal thoughts |
| <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Weight loss or gain | <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Financial problems |
| <input type="checkbox"/> Agitation | <input type="checkbox"/> Headaches | <input type="checkbox"/> Relationship problems |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Substance abuse in family |

10. Do you think you might have a problem with alcohol or drugs? yes no possibly

11. When did you last get drunk or high on drugs? _____

12. During the last 6 months how frequently have you used the following? (Please check all that apply):

	Daily	Weekly	2 or more weekly	Monthly	1 Time only	Never
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PCP/LSD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glue, Paint, Gasoline, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. Have you ever had any legal problems due to alcohol/drug use (i.e. D.U.I., D.W.I.)? Yes No

14. Have you ever had any of the following problems?:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/Bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding tendency/bruising	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia/Pleurisy
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaund./Hepatitis/Liver Cirrhosis
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease/Goiter	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder trouble or Gallstones
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Stomach trouble/Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Bowel disorders/Colitis
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids (piles)
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumors
<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble or Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or Bladder trouble
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease (Syphilis, Gonorrhea)
<input type="checkbox"/>	<input type="checkbox"/>	Stroke or Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Nervous/Emotional problem
<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis/Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Hay fever			

15. List any serious illnesses, injuries, and surgeries you have had (give year): _____
