

ADULT HISTORY QUESTIONNAIRE

Client Name: _____ D.O.B: _____ Age: _____

PRESENTING PROBLEM

Reason for Referral: _____

When and how were you first made aware of this problem? _____

How often does the problem occur? _____

How long does it last? _____

On a scale of 1-100 (Mild-Severe) How intense would you rate the problem? _____

Do you exhibit difficulties: At Home? Yes/No At Work? Yes/No

Explain: _____

Do you currently have a diagnosis? _____

Other professionals involved (e.g. physician, psychologist, psychiatrist, etc): _____

Previous psychological/psychiatric treatment: _____

DEVELOPMENTAL / HEALTH FACTORS

Hospitalizations, accidents, or surgeries: _____

Medications currently being taken, dosage, and reason: _____

Problems with vision? Yes/ No Wears glasses? Yes/ No

Problems with hearing? Yes/ No _____

Motor Concerns (coordination, balance, fine/gross motor skills)? Yes/ No _____

Speech/Language Concerns? Yes/No _____

Has anything unusual or out of the ordinary occurred in development? _____

FAMILY HISTORY

Marital status? Single Married Separated Divorced Widowed Remarried

How many years married? _____ How long have you been separated/divorced? _____

Children? Yes/No Ages _____

Who lives in the home? _____

Family strengths: _____

Family challenges: _____

Briefly describe a typical evening in your household: _____

Describe family history of psychiatric/psychological, academic, legal and substance abuse problems? _____

EDUCATIONAL/VOCATIONAL BACKGROUND

Education/Jobs

Describe employment difficulties: _____

When did these problems begin? _____

SOCIAL /EMOTIONAL DEVELOPMENT

Describe your temperament/mood: _____

How do you get along with peers? _____

Activities the client enjoys: _____

Describe any current social/emotional concerns? _____

Behavioral/Emotional difficulties: _____

Traumatic events experienced (e.g. death of someone close, abuse, divorce): _____

Circle any of the following that you are currently experiencing:

- | | | |
|--------------------|----------------------------|---------------------|
| Mood swings | sleep difficulties | nightmares |
| depression | anxiety | memory loss |
| suicidal ideation | dangerous behaviors | prefers to be alone |
| attention problems | poor appetite | aggression |
| restlessness | anger outbursts | excessive worry |
| motor/vocal tics | poor frustration tolerance | |

What are your strengths? _____

What are your weaknesses? _____

ADDITIONAL INFORMATION

What are your expectations for coming to this office? _____

Any additional information that would assist in understanding your difficulties? _____

Is there any other problem or question that you would like addressed or any other area in which you need assistance? _____