ADULT PATIENT QUESTIONNAIRE

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Date: _____ Referred By: _____

Full Name: _____Age: _____DOB: _____Male/Female: _____

Home Ph: _____Cell Ph: _____Email: _____

PRESENTING PROBLEMS

1. **Briefly describe the problem or concern you most wish help with currently:**
   _____
   _____
   _____

2. **How would you rate the intensity of the problem or concern that led you to seek professional services?**

Not Intense		Somewhat Intense		Very Intense
1	2	3	4	5

3. **Approximately how long have you had the current problem or concern? _____**

4. **In what ways have you attempted to cope with this problem or concern?**
   _____
   _____
   _____

5. **How important is it to you that you make the changes that you want to make in therapy?**

Not Important		Somewhat Important		Very Important
1	2	3	4	5

6. **How confident are you that you can make these changes?**

Not Confident		Somewhat Confident		Very Confident
1	2	3	4	5

CULTURAL BACKGROUND

7. What is your race/ethnicity?

- ☐ White (non-Hispanic/Latino)
- ☐ Hispanic/Latino
- ☐ Black/African American
- ☐ Asian American
- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian/Pacific Islander
- ☐ Multiracial (please specify): _____
- ☐ International (please specify): _____

8. How much do you identify with your ethnic heritage?

- ☐ not at all
- ☐ a little
- ☐ somewhat
- ☐ moderately
- ☐ strongly

9. Religious or spiritual preference: _____

10. Are you currently active in your religion?

- ☐ yes
- ☐ somewhat
- ☐ no

11. Does your family speak a language other than English at home?

- ☐ not at all
- ☐ very little
- ☐ sometimes
- ☐ frequently
- ☐ always

If so, which? _____

12. Were you and both your biological parents born in the U.S.?

- ☐ yes
- ☐ no
- ☐ unsure

If no, who was foreign-born, in what country, and their approximate age of immigration to the U.S.?

_____

FAMILY BACKGROUND

13. Please list the members of your family of origin.

Name	***Gender***	***Age***	***Bio/Step?***	***Occupation***	***Education***
Father:					
Mother:					
Sibling 1:					
Sibling 2:					
Sibling 3:					
Sibling 4:					
Sibling 5:					
Sibling 6:					

14. Is your father deceased?

☐ Yes ☐ No Year? _____ Age _____

15. Is your mother deceased?

☐ Yes ☐ No Year? _____ Age _____

16. What is/was your parents' marital status?

☐ married ☐ divorced ☐ father remarried
☐ separated ☐ mother remarried

17. Describe your relationship with your <u>father</u> growing up: _____

_____

_____

18. Describe your relationship with your <u>mother</u> growing up: _____

_____

_____

19. Describe your relationship with your <u>father</u> now: _____

_____

_____

20. Describe your relationship with your <u>mother</u> now: _____

_____

_____

21. Do any members of your family suffer from mental health problems (i.e. depression, anxiety, OCD, schizophrenia, Bipolar, Autism, alcoholism, drug use, etc)? If so, explain: _____

_____

_____

22. Were you ever physically or sexually abused as a child:

☐ yes ☐ no

If Yes, explain: _____

_____

_____

EDUCATION INFORMATION AND WORK HISTORY

23. Please indicate your educational level.

☐ less than high school
☐ H.S. equivalent/GED
☐ high school diploma
☐ vocational
☐ some college (no degree completed)
☐ bachelor's degree
☐ master's degree
☐ doctoral degree
☐ other_____

24. What was your major/minor/area of concentration? _____

25. Did you experience any learning problems in school?

☐ none ☐ some ☐ always/constant
☐ little ☐ substantial struggle

26. How satisfied are you with your academic progress so far? (please circle)

Not Satisfied		Somewhat Satisfied		Very Satisfied
1	2	3	4	5

27. What barriers, if any, are impeding your academic progress? _____

28. What is your current job or occupation? _____

29. Where are you employed? _____

30. How satisfied are you with your current job and or occupation? (please circle)

Not Satisfied		Somewhat Satisfied		Very Satisfied
1	2	3	4	5

MEDICAL INFORMATION

31. Are you currently experiencing any physical pain?

☐ yes ☐ no

If yes, which parts of your body are in pain? _____

_____

32. On a scale of 1 – 10, with 10 being excruciating pain and 1 being mild pain, how would you rate the pain? _____

Is this pain: Constant?____ Intermittent?____ Occasional? _____

33. Check if you are currently experiencing any of the following symptoms:

	Never	**Rarely**	**Frequently**	**Very Often**
Diarrhea	_____	_____	_____	_____
Constipation	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____
Heart Problems	_____	_____	_____	_____
Nausea	_____	_____	_____	_____
Vomiting	_____	_____	_____	_____
Headaches	_____	_____	_____	_____

Describe any other symptoms and rate how often it occurs: _____

_____

34. Have you ever been diagnosed with (please circle):

Cancer Y N	Heart Problems Y N
Diabetes Y N	High blood pressure Y N
Asthma Y N	Ulcers Y N
Stomach Problems Y N	Seizures Y N
Arthritis Y N	Thyroid Problems Y N
Epilepsy Y N	Fibromyalgia Y N
Sleep Apnea Y N	Stroke Y N
Multiple Sclerosis Y N	Chronic Fatigue Syndrome Y N

Other: _____

35. Have you ever injured your head? Y N

36. Have you ever lost consciousness? Y N

37. FOR WOMEN: State how many times you have been pregnant, given birth, miscarried or terminated a pregnancy.

Year of Pregnancy	Year of Birth	Year of Miscarriage	Year of Pregnancy Termination

38. Are you having any problems with your sleep habits?

☐ yes ☐ no

If yes, check where applicable:

☐ sleeping too little
☐ sleeping too much
☐ other _____
☐ poor quality sleep
☐ disturbing dreams

39. How many times per week do you exercise? _____ For how long? _____

40. Are you having any difficulty with appetite or eating habits?

☐ yes ☐ no

If yes, check where applicable:

☐ eating less
☐ eating more
☐ significant weight change (in past two months)
☐ binge eating
☐ restricting calories

41. Do you regularly use alcohol?

☐ yes ☐ no

In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

42. Have you ever tried to cut down on the amount of alcohol you consume?
☐ yes ☐ no

43. Has anyone close to you ever been annoyed by your drinking?
☐ yes ☐ no ☐ unsure

44. Do you consider your alcohol consumption to be a problem?
☐ yes ☐ no ☐ unsure

45. List types of drugs used, frequency of use, and dates of use:

Type: _____ Frequency: _____ Dates (from/to): _____
Type: _____ Frequency: _____ Dates (from/to): _____
Type: _____ Frequency: _____ Dates (from/to): _____
Type: _____ Frequency: _____ Dates (from/to): _____
Type: _____ Frequency: _____ Dates (from/to): _____

46. Do you consider this drug use to be a problem?
☐ yes ☐ no ☐ unsure

MARITAL/SOCIAL INFORMATION

47. How would you rate the quality of your <u>friend/peer</u> relationships?
☐ very poor ☐ average ☐ excellent
☐ unsatisfactory ☐ good

48. Approximately how many <u>significant intimate relationships</u>, lasting six months or more, have you had?
_____
Are you currently in one? ☐ yes ☐ no

49. Do you have any problems or worries about sexual functioning?
☐ yes ☐ no

If yes, check where applicable:
☐ performance problem ☐ lack of desire
☐ sexual impulsiveness ☐ difficulty maintaining arousal
☐ other: _____

50. Besides family members, approximately how many people can you really count on currently for friendship or emotional support? _____

51. What is your current relationship status?
☐ Single ☐ Widowed ☐ Committed relationship
☐ Divorced ☐ Married ☐ Remarried
☐ Separated ☐ Engaged

52. What is your spouse's/partner's: Name _____ Age _____
Occupation _____ Education _____

53. How long have you been married/together: _____

54. Has there ever been domestic violence?
☐ yes ☐ no

If Yes, explain: _____

_____

_____

55. How would you rate your relationship satisfaction

Not Satisfied		Somewhat Satisfied		Very Satisfied
1	2	3	4	5

56. Has your spouse/partner had (or currently has) a significant medical issue or mental health problem:

If yes, explain: _____

_____

57. Have you or your spouse ever been divorced?

If yes, list dates and length of marriages: _____

_____

58. Please list any children of yours

Name	***Gender***	***Age***	***Adopted? (Yes or No)***
Child 1:			
Child 2:			
Child 3:			
Child 4:			
Child 5:			

59. How do you spend your leisure time?

_____

_____

60. Have you ever experienced legal problems? ☐ yes ☐ no

If yes, nature of problem: _____

MENTAL HEALTH HISTORY

61. Are you currently receiving psychiatric services, professional counseling, or therapy elsewhere?
☐ yes ☐ no

62. Have you ever had previous counseling or psychotherapy? ☐ yes ☐ no

If yes, please specify the following:

Reason for counseling:_____
Counseling location: _____
Counseling date: _____
Counseling duration: _____
What did you like most about the counseling: _____
_____
What did you like the least: _____
_____

63. Have you ever been hospitalized for psychiatric reasons? ☐ yes ☐ no

If yes, please specify the following:
Reason for hospitalization: _____
Hospital location: _____
Dates of hospitalization: _____
Duration of hospitalization: _____

64. List all prescription medication (psychiatric and non-psychiatric)

Name	**Dosage**	**Frequency**	**Date first prescribed**	**Prescribing physician**

65. Have you had suicidal thoughts recently? ☐ yes ☐ no

If yes, how often?
☐ daily ☐ weekly ☐ monthly ☐ rarely

66. Have you had suicidal thoughts in the past? ☐ yes ☐ no

If yes, how often?
☐ daily ☐ weekly ☐ monthly ☐ rarely

67. Have you ever intentionally inflicted harm upon yourself? ☐ yes ☐ no

If yes, how often?
☐ daily ☐ weekly ☐ monthly ☐ rarely

Nature of harm: _____

68. Have you ever intentionally hurt someone else? ☐ yes ☐ no

Nature of harm: _____

69. Have you ever experienced any form of traumatic experience? ☐ yes ☐ no

When? _____

Nature of experience: _____

70. Have you ever experienced sexual assault, unwanted sex, or uncomfortable touching?

- ☐ frequently
- ☐ a few times
- ☐ once
- ☐ never
- ☐ unsure

OTHER INFORMATION

71. How does the future look to you?

- ☐ poor
- ☐ fair
- ☐ neutral
- ☐ good
- ☐ excellent

72. Briefly describe your plans for the future.

_____

_____

_____

73. What do you hope to accomplish through counseling?

_____

_____

_____

74. Is there anything else you would like me to know about you?

_____

_____

_____