ADULT HISTORY QUESTIONNAIRE

The following information is used to best determine a treatment plan. Completing this form as fully and accurately as possible will help facilitate this process. If you need additional space for any of your answers, please use space at the end of this form. If you feel uncomfortable answering any of the questions, feel free to put an "X" through those sections.

PERSONAL DATA

Name: _____

DOB: _____ Age: _____ Gender: □ male □ female

Where were you born? _____

How long have you lived in the city you live in currently? _____

Who do you live with? _____

What culture/ethnicity do you consider yourself? _____

What do you like to do for fun? (hobbies, activities) _____

Current relationship status: □ single □ married □ separated □ divorce □ partnered/other

Is there anything about your current or past relationships that would be helpful to know in counseling?

_____

_____

_____

_____

FAMILY HISTORY

FATHER

Name: _____ Age: _____

Occupation: _____ Health issues? _____

How do you get along with your father? □ poor □ average □ great

Is there anything about your relationship with your father that would be helpful to know in counseling?

_____

_____

MOTHER

Name: _____ Age: _____

Occupation: _____ Health issues? _____

How do you get along with your mother? □ poor □ average □ great

Is there anything about your relationship with your mother that would be helpful to know in counseling?

_____

_____

SIBLINGS

Names	Ages	How do you get along?
_____	_____	□ poor □ average □ great
_____	_____	□ poor □ average □ great
_____	_____	□ poor □ average □ great

CHILDREN

Names	Ages	Where do they live?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any fearful of distressing experiences regarding your family life which stand out in your mind which were not previously mentioned? (briefly describe) _____

Are there other family members that you are close with? _____
Do you have people outside your biological family that you feel are "like family" and in whom you can confide? _____

WORK HISTORY

Current occupation: _____

Do you have any career/work concerns? _____

MEDICAL HISTORY

When was your last physical? _____
List any current medical conditions you are aware of: _____

Do you regularly take any medications? (please list) _____
Name and phone number of physician: _____
Are you aware of any significant information about your birth or development? _____

MENTAL HEALTH HISTORY

Have you ever received counseling treatment in the past? ☐ yes ☐ no If yes, please list:

Dates of Care	Provider	Purpose/Outcome
_____	_____	_____
_____	_____	_____

Have you ever been hospitalized for a mental health condition? ☐ yes ☐ no If yes, please describe when, where and why: _____

Have you ever thought about or attempted to harm yourself in any way? ☐ yes ☐ no
If yes, please explain: _____

Have you ever thought about or inflicted physical violence on another person? ☐ yes ☐ no
If yes, please explain: _____

List any family history of mental health problems. Please list the relation to you: _____
_____

Are you currently taking any psychiatric medications? □ yes □ no If yes, please list medication, dosage and prescriber: _____

Any psychiatric medication taken in the past? (please list) _____

DRUG & ALCOHOL USE

Do you think drug or alcohol use contributes to your current problems in life? □ yes □ no
If yes, please explain current substance use:_____

Have you ever been in drug/alcohol treatment? □ yes □ no
If yes, please explain: _____

PRESENT CONCERNS

Please briefly describe your reasons for seeking counseling at this time: _____

Please check any of the following feelings or symptoms that apply to you**:**

- □ depressed, withdrawn
- □ feel inferior, not good enough
- □ hopelessness
- □ crying spells
- □ mood swings
- □ poor concentration
- □ poor memory
- □ low energy
- □ anxious/worried
- □ specific fears
- □ panic attacks
- □ sleep problems
- □ sleeping more than usual
- □ relationship problems
- □ feeling detached from others
- □ angry or irritable
- □ poor appetite
- □ food binging
- □ food purging
- □ difficulty making decisions
- □ feeling guilty
- □ unable to relax
- □ unable to enjoy myself
- □ memory lapse/loss
- □ fearing a loss of control
- □ thoughts of harming or killing myself
- □ self harm/cutting
- □ impulsivity
- □ fighting or bullying
- □ running away
- □ lying
- □ lack of interest in previously enjoyed activities

Please describe how you would like life to be different when you are done with counseling: _____

Is there any other information that you think I should know prior to beginning to work together? _____