History Questionnaire- Adult

Please take time to fill out this form.
This will aid greatly in providing appropriate therapeutic care for you.

Name: _____ DOB: _____

BIRTH HISTORY

Did your mother do any of the following when she was pregnant with you?

☐ Yes ☐ No Drink Alcohol
☐ Yes ☐ No Smoke Cigarettes
☐ Yes ☐ No Was Depressed

Describe if yes is marked for any of the above:

_____

_____

Birth Weight _____ lbs _____ oz

☐ Yes ☐ No Any complications with labor or delivery?

Describe if yes: _____

_____

DEVELOPMENTAL HISTORY

☐ Yes ☐ No Did you have any problems (physical, emotional, etc.) in your early childhood?

Describe if yes: _____

_____

☐ Yes ☐ No Did you experience any developmental delays as a child?

Describe if yes: _____

_____

List any childhood illnesses, serious accidents, or hospitalizations:

Age at time of incident:	Describe incident:

☐ Yes ☐ No	History of head injury or loss of consciousness	Describe: _____
☐ Yes ☐ No	History of seizures	Describe: _____
☐ Yes ☐ No	Allergies	Describe: _____
☐ Yes ☐ No	Current health problems	Describe: _____
☐ Yes ☐ No	Current infectious disease(s)	Describe: _____
☐ Yes ☐ No	Current medications	Describe: _____
	Name of medications:	_____
	Dose/frequency:	_____

Additional comments: _____

_____

_____

List any other people living in your home at this time:

Name _____ Age: _____ Relationship to you: _____
Name _____ Age: _____ Relationship to you: _____
Name _____ Age: _____ Relationship to you: _____
Name _____ Age: _____ Relationship to you: _____
Name _____ Age: _____ Relationship to you: _____
Name _____ Age: _____ Relationship to you: _____

List other important family members or relatives living outside the home:

Name _____ Age: _____ Relationship to you: _____
Name _____ Age: _____ Relationship to you: _____
Name _____ Age: _____ Relationship to you: _____
Name _____ Age: _____ Relationship to you: _____
Name _____ Age: _____ Relationship to you: _____

Which of the following describes your current living situation?

☐ Rent apartment ☐ Rent house ☐ Own house
☐ Foster care ☐ Condominium ☐ Shelter
☐ Homeless ☐ Group home ☐ Residential treatment

What is the primary language spoken in your home? _____

Current Employer: _____
Job Title: _____
How long: _____

FAMILY HISTORY

List the places you have lived for the past five years:

	Where:	With whom:	Dates (from-to):
1.			
2.			
3.			
4.			
5.			

Have you ever experienced any of the following?

☐ Yes ☐ No Physical Abuse Age/Describe: _____
☐ Yes ☐ No Sexual Abuse Age/Describe: _____
☐ Yes ☐ No Assault Age/Describe: _____
☐ Yes ☐ No Death of a parent Age/Describe: _____
☐ Yes ☐ No Death of a relative Age/Describe: _____
☐ Yes ☐ No Death of a friend Age/Describe: _____
☐ Yes ☐ No Parental separation Age/Describe: _____

Additional Information:

_____
_____
_____
_____
_____

Please describe on both parents' side of the family any history of mental illness, suicide, legal problems, chemical abuse or dependency and physical/sexual abuse. If it is someone else, describe his or her relationship to you (i.e. paternal uncle- alcoholic, mother- depression, etc):

Mother's side of the family:

☐ Yes ☐ No Alcohol abuse If yes, whom? _____
☐ Yes ☐ No Substance abuse If yes, whom? _____
☐ Yes ☐ No Mental Health problems If yes, whom? _____
☐ Yes ☐ No Physical abuse If yes, whom? _____
☐ Yes ☐ No Sexual abuse If yes, whom? _____

Father's side of the family:

☐ Yes ☐ No Alcohol abuse If yes, whom? _____
☐ Yes ☐ No Substance abuse If yes, whom? _____
☐ Yes ☐ No Mental Health problems If yes, whom? _____
☐ Yes ☐ No Physical abuse If yes, whom? _____
☐ Yes ☐ No Sexual abuse If yes, whom? _____

Other issues currently affecting family members:

☐ Yes ☐ No Health problems If yes, describe: _____
☐ Yes ☐ No Disabilities If yes, describe: _____
☐ Yes ☐ No Legal issues If yes, describe: _____
☐ Yes ☐ No Financial concerns If yes, describe: _____

HEALTH/MEDICAL

Describe yourself in the following areas:

Sleeping habits: _____

_____

Eating habits: _____

_____

Energy level: _____

_____

☐ Yes ☐ No Do you or anyone living with you have an infectious disease?

If yes, what? _____

CHEMICAL HEALTH

☐ Yes ☐ No Have you ever had a chemical health assessment done?

If yes, when? _____

☐ Yes ☐ No Have you ever had any chemical dependency treatment?

If yes, when? _____

Describe your use of drugs or alcohol at this time:

☐ Yes ☐ No Cigarettes Describe: _____
☐ Yes ☐ No Alcohol Describe: _____
☐ Yes ☐ No Marijuana Describe: _____
☐ Yes ☐ No Inhalants Describe: _____
☐ Yes ☐ No Methamphetamines Describe: _____
☐ Yes ☐ No Cocaine/Crack Describe: _____
☐ Yes ☐ No Acid/LSD Describe: _____
☐ Yes ☐ No Other Describe: _____
☐ Yes ☐ No Previous chemical use problems Describe: _____

Describe your spouse/partner's use of drugs or alcohol at this time: (if applicable)

☐ Yes ☐ No Cigarettes Describe: _____
☐ Yes ☐ No Alcohol Describe: _____
☐ Yes ☐ No Marijuana Describe: _____
☐ Yes ☐ No Inhalants Describe: _____
☐ Yes ☐ No Methamphetamines Describe: _____
☐ Yes ☐ No Cocaine/Crack Describe: _____
☐ Yes ☐ No Acid/LSD Describe: _____
☐ Yes ☐ No Other Describe: _____
☐ Yes ☐ No Previous chemical use problems Describe: _____
☐ Yes ☐ No Previous chemical dependency treatment: Describe: _____

SCHOOL

Highest grade level completed: _____

Describe what school was like for you: _____

Please list any other stressors that may be affecting you or your family at this time:

SUPPORTIVE FACTORS

List any previous mental health services you have received:

	Clinic Name:	Therapist Name:	Dates:	Was it helpful?
1.	_____	_____	_____	☐ Yes ☐ No
2.	_____	_____	_____	☐ Yes ☐ No
3.	_____	_____	_____	☐ Yes ☐ No
4.	_____	_____	_____	☐ Yes ☐ No

☐ Yes ☐ No Do you have a probation officer?
☐ Yes ☐ No Are you involved with a county Social Worker?
☐ Yes ☐ No Do you have any other service providers?

Describe: _____

Who are the people or services that you find supportive to you and your family (i.e. church, relatives)? Please be specific.

Describe the role of religious and/or spiritual influences on your family:

Describe any extracurricular activities you have or recreational hobbies you participate in:

Please check any areas that you may be concerned about:

- ☐ Depression
- ☐ Anxiety
- ☐ Gambling too much
- ☐ Weight Loss
- ☐ Learning Difficulties
- ☐ Chemical Use
- ☐ Fighting
- ☐ Stealing
- ☐ Violence
- ☐ Crying a lot
- ☐ Physical Abuse
- ☐ Nightmares
- ☐ Strange Behaviors
- ☐ Promiscuity
- ☐ Hyperactivity
- ☐ Lack of Friends
- ☐ Panic Attacks
- ☐ Physical Problems with No Known Medical Cause
- ☐ Sexual Abuse
- ☐ Obsessive Behaviors
- ☐ Excessive Worrying
- ☐ Paranoia
- ☐ Suicidal thoughts/plans
- ☐ Perfectionist
- ☐ Avoid Others
- ☐ Self Injurious Behavior
- ☐ Obsessive Thoughts
- ☐ Hot Temper
- ☐ Gender Confusion
- ☐ Destroy Things
- ☐ Odd beliefs
- ☐ Mood Changes
- ☐ Can't Pay Attention
- ☐ Fire Setting

Use this space to elaborate about anything you mentioned above that you are concerned about:

_____

_____

YOUR STRENGTHS (Check all that apply)

- ☐ Stay Active
- ☐ Independent
- ☐ Helpful
- ☐ Share with Others
- ☐ Good Looking
- ☐ Athletic
- ☐ Good Health
- ☐ Employed
- ☐ Positive Outlook
- ☐ Easy Going
- ☐ Maintain Friends
- ☐ A Leader
- ☐ Liked by Others
- ☐ Honest
- ☐ Attend school/Work Regularly
- ☐ Spiritual
- ☐ Intelligent
- ☐ Hard Working
- ☐ Have a hobby
- ☐ Structure Time Well
- ☐ Volunteers
- ☐ Cope with problems well
- ☐ Humorous
- ☐ Caring
- ☐ Playful
- ☐ Artistic
- ☐ Responsible
- ☐ Positive view of the world
- ☐ Others: _____

FAMILY STRENGTHS (Check all that apply)

- ☐ Partner Employed
- ☐ Clear Rules at Home
- ☐ Sense of Humor
- ☐ Knows Child's Friends
- ☐ Consistent Parenting
- ☐ Go on Vacations Together
- ☐ Relatives Involved with Child
- ☐ Good Support Network
- ☐ Volunteer in Community
- ☐ Parents Get Along
- ☐ Often Eat Supper Together
- ☐ Do Activities Together
- ☐ Involved at Child's School
- ☐ Help Children with Problems
- ☐ Know Parents of Child's Friends
- ☐ Attend Church
- ☐ Caring
- ☐ Resilient
- ☐ Good Communication
- ☐ Able to Show Affection
- ☐ Strong Ethnic/Cultural Identity
- ☐ Know How Child is Doing at School
- ☐ Children have Jobs in the Home
- ☐ Others: _____

What would you like to see come out of services for yourself?

_____

_____

_____

Is there any other information that would be helpful to know in helping you?

_____

_____

_____

COMPLETED BY: _____ DATE: _____