

## Personal Questionnaire—Adult (18+)

Client's name: \_\_\_\_\_ Date: \_\_\_\_\_

Gender: \_\_\_\_\_ F \_\_\_\_\_ M Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Form completed by (if someone other than client): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (home): \_\_\_\_\_ (work): \_\_\_\_\_ ext: \_\_\_\_\_

If you need any more space for any of the questions please use the back of the sheet.

Primary reason(s) for seeking services: (Circle any that apply)

Anger management    Anxiety    Coping    Depression    Eating disorder

Fear/phobias    Mental confusion    Sexual concerns    Sleeping problems

Addictive behaviors    Alcohol/drugs    Career    Parenting    Self-Esteem/Worth

Compulsive Thinking/Behavior

Other concerns (specify): \_\_\_\_\_

Relationship Concerns: \_\_\_\_\_

### Please Describe Current Family Situation

Marital Status:    Single    Divorced    Remarried (How many times)    Quality of family life

Children:

### Your Childhood

Grew Up Where:

What was it like growing up:

Social Relationships:

Cultural/Ethnic Background:

Spiritual/Religious Background and Current:

Legal History and Current:

**Education**

Please describe any learning disabilities, gifted, how far have you gone with education):

**Employment**

Begin with most recent job, list job history:

Employer	Dates	Title	Reason left the job	How often miss work?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Currently:  FT  PT  Temp  Laid-off  Disabled  
 Retired  Social Security  Student  Other (describe):

**Military**

Military experience?  Yes  No    Combat experience?  Yes  No

Where: \_\_\_\_\_

Branch: \_\_\_\_\_ Discharge date: \_\_\_\_\_

Type of discharge: \_\_\_\_\_ Rank at discharge: \_\_\_\_\_

**Leisure/Recreational**

What kind of activities do you enjoy and participate in:

**Medical/Physical Health**

List any past health problems:

List any current health Problems:

<b><u>Current prescribed medications</u></b>	Dose	Dates	Purpose	Side effects
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Chemical Use History(Please describe your use of alcohol and drugs)**

**Counseling/Prior Treatment History**

Information about client (past and present): Counseling, Psychiatric(inpatient & outpatient), Drug & Alcohol

Where \_\_\_\_\_ When \_\_\_\_\_ Outcome \_\_\_\_\_

Information about family member's mental health history (past and present):

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Aggression          | <input type="checkbox"/> Elevated mood       | <input type="checkbox"/> Phobias/fears          |
| <input type="checkbox"/> Alcohol dependence  | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Recurring thoughts     |
| <input type="checkbox"/> Anger               | <input type="checkbox"/> Gambling            | <input type="checkbox"/> Sexual addiction       |
| <input type="checkbox"/> Antisocial behavior | <input type="checkbox"/> Hallucinations      | <input type="checkbox"/> Sexual difficulties    |
| <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Heart palpitations  | <input type="checkbox"/> Sick often             |
| <input type="checkbox"/> Avoiding people     | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleeping problems      |
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Hopelessness        | <input type="checkbox"/> Speech problems        |
| <input type="checkbox"/> Cyber addiction     | <input type="checkbox"/> Impulsivity         | <input type="checkbox"/> Suicidal thoughts      |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Thoughts disorganized  |
| <input type="checkbox"/> Disorientation      | <input type="checkbox"/> Judgment errors     | <input type="checkbox"/> Trembling              |
| <input type="checkbox"/> Distractibility     | <input type="checkbox"/> Loneliness          | <input type="checkbox"/> Withdrawing            |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Memory impairment   | <input type="checkbox"/> Worrying               |
| <input type="checkbox"/> Drug dependence     | <input type="checkbox"/> Mood shifts         | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Eating disorder     | <input type="checkbox"/> Panic attacks       |   |

Briefly discuss how the above symptoms impair your ability to function effectively:

What are your goals for therapy?:

Do you feel suicidal at this time? \_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes, explain:

Therapist's signature: \_\_\_\_\_ Date: \_\_\_\_\_

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