Adult Questionnaire
Revised: 1/8/2021

Name:_____ **Birthdate:** _____
First Middle Last (MM/DD/YYYY)

Address:_____ **Phone:** _____

Email:_____ **Gender & pronoun preference:** _____

Have you ever served in the armed forces: Yes No

Do you consent to receive occasional texts and emails? YES NO (This will be limited to appointment reminders, cancellations, etc.) **Who is your cell phone provider?**

What are your reasons for being seen today?

Previous Counseling/Psychiatric/ Addictions treatment:
Past Psychiatric History - for yes answers, obtain ROI
Have you ever had therapy or counseling for mental health or addictions? **YES NO**
When, with whom & was it helpful?

Have you ever seen a psychiatrist? **YES NO**
If yes, when, with whom and what was your diagnosis:

Have you ever been hospitalized in a psychiatric hospital? **YES NO**
If yes, why, where, when, and for how long:

Have you ever hurt yourself or tried to commit suicide? **YES** **NO**
If yes, by what means?

Are you currently experiencing suicidal ideation?

Medical:
Who is your primary care provider and at which clinic is he/she employed?

What is your preferred pharmacy and location?

What current medical conditions do you have and what past surgeries have you had?

What are your current medications and dosages? Include anything over the counter. Also note any negative side effects:

Please list any allergies, particularly any allergies to medications:

Have you ever had a head injury?	**YES**	**NO**
Have you ever had a seizure?	**YES**	**NO**
History of abuse?	**YES**	**NO**
History of trauma?	**YES**	**NO**

FEMALES
Are you currently pregnant? NO_____YES _____
Do your symptoms happen or worsen before your menstrual cycle? NO_____YES _____
Are you currently taking birth control: NO _____ YES_____

Family History:
Marital Status: **Single** **Married** **Divorced** **Widowed**
Ages of Children:

List siblings, ages and history of mental illness or addictions:

Summarize your parents' health history, including mental health diagnosis:

Substance use History:

Alcohol:	Last Use:	How often/how much:
Nicotine:	Last Use:	How often/how much:
Caffeine:	Last Use:	How often/how much:
Marijuana:	Last Use:	How often/how much:
Cocaine/Crack:	Last Use:	How often/how much:
Heroin:	Last Use:	How often/how much:
LSD:	Last Use:	How often/how much:
Methamphetamine:	Last Use:	How often/how much:
Fentanyl/Opioids:	Last Use:	How often/how much:
Other:	Last Use:	How often/how much:

Have you ever detoxified when quitting alcohol use?

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Personal background:

When and from where did you graduate from high school or earn your GED? Also list any post-secondary education:

Summarize your work history:

Hobbies or social activities:

Religious preference:

Do you have any current or "past" legal charges? If so what? Who is your attorney and/or corrections officer?

What are your strengths?

What are your treatment goals you'd like to achieve?

Is there anything else you would like to discuss today?