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Adult Health and Psychosocial History Questionnaire

Name________________________________ Date of Birth__________________Today's Date ___________

Reason Seeking Treatment:____

____

Goals for Treatment:____

Past/Current Medical/Emotional Conditions *(Please check all that apply):*

__Abnormal Blood Pressure
__Accidents
__ Addictions/Using
  __ Food __ Caffeine
  __ Drugs __Alcohol
  __Sex __Spending
  __ Medication misuse
  __ Nicotine
  __ Other: __________
__ Allergies: _________
__ Anemia
__ Anger Issues
__ Anxiety
__ Appetite Disturbance
__ Arthritis
__ Asthma
__ Aches/Pain
__ Cancer
__ Compulsions
__ Concentration Difficulties
__ Crying Spells
__ Depression
__ Diabetes
__ Diarrhea/Constipation
__ Dizziness
__ Eating Disorder
__ Epilepsy/Seizure Disorder
__ Emphysema
__ Fainting Spells
__ Fatigue
__ Fibromyalgia
__ Hallucinations
__ Headaches
__ Head Injury
__ Hearing Problems
__ Heart Problems
__ Hopelessness
__ Hormone Imbalances
__ HIV/AIDS
__ Indigestion
__ Irritable Bowel Syndrome
__ Irritability
__ Kidney/Bladder Problems
__ Liver Disease
__ Memory Loss
__ Migraines
__ Nausea/Vomiting
__ Mood Swings
__ Neurological Disorders
__Obsessions
__ Panic Attacks
__ Phobias/Fears
__ Sexual Issues
__ Sleep Problems
__ Social Withdrawal
__ Stroke
__ Thyroid Problems
__ Ulcers/ Abdominal Pain
__ Venereal Disease
__ Vision Problems
__ Weight Loss/Gain
__ Other_____________

Additional Comments on Medical/Emotional Conditions:____

____

____

Primary Care Physician ______________________________________Phone (   ) _______________________

Address ____

Psychiatrist ____Phone (   ) _________________________

Address ____

May we contact your physician about your care? [ ] yes [ ] no [ ] Don't have a primary physician

Current Medication	Dosage	Frequency	Prescribing Doctor	Reason & Side Effects

Yes	No	**Previous Treatment**	Provider or Facility	Dates
		Have you ever received Counseling or outpatient treatment for Mental Health issues?		
		Have you ever received inpatient or partial hospitalization for Mental Health issues?		

Yes	No	**Previous Treatment**	Provider or Facility	Dates
		Have you ever received outpatient treatment for Alcohol/Drug problems?		
		Have you ever received inpatient or partial hospitalization for alcohol or drug problems.		

If yes to previous treatment, what did you find **most helpful** in therapy?____________________________

____

What did you find **least helpful** in therapy?____

____

Current Social, Family and Environmental Stressors *(Please check all that apply):*

__ Abuse: Emotional, Physical, Sexual
__ Accidents
__ Birth, Adoption, Foster child
__ Death of ____________________
__ Divorce/Separation
__ Drug/Alcohol Abuse
__ Employment Change/Difficulties
__ Family Relation Conflicts
__ Financial Struggles
__ Legal Issues
__ Illness
__ Marriage (Recent)
__ Marital Difficulties
__ Miscarriage
__ Residential Move
__ School Difficulties
__ Separation/Abandonment
__ Other: ______________________
____
____

Please check the column that best describes how you feel you are doing in each life area.

LIFE AREA	1. No Problems	2. Mild	3. Moderate Problems	4. Significant	5. Serious Problems
Work/Job					
Marriage/Significant Other					
Parenting					
Social Life					
Financial					
Intimacy/Sexuality					
Family of Origin					
Legal					
School					
Other Relationships					
Physical Health					
Happiness/Well Being					

Social and Leisure Activities

Identify exercise, interests, leisure/recreational activities that you participate in: ______________________________

____

Personal Strengths

Please identify:____

____

Spirituality

Do you have a religious preference? [ ]Yes [ ]No Describe ____

____

Is your spiritual belief system part of your support system? [ ] Yes [ ] No

Do you have any spiritual concerns you would like to address in therapy? [ ] Yes [ ] No

Cultural

What is your cultural heritage?____

Are there any cultural expectations, values or pressures causing conflicts in your life? [ ] Yes [ ] No

If yes, please explain: ____

____

Pain and Pain Management

Do you have any problems with chronic pain? [ ] Yes [ ] No

If yes, please explain: ____

____

How do you manage physical pain?

____

____

How do you manage emotional pain?

____

____

What else would you like your therapist to know?

____

____

____

____

____

____

____

Client Signature____ Date ____________________________