ADULT HISTORY QUESTIONNAIRE

Client Name: _____ D.O.B:_____ Age: _____

PRESENTING PROBLEM

Reason for Referral: _____

_____

_____

When and how were you first made aware of this problem? _____

_____

How often does the problem occur? _____

How long does it last? _____

On a scale of 1-100 (Mild-Severe) How intense would you rate the problem? _____

Do you exhibit difficulties: At Home? Yes/No At Work? Yes/No

Explain: _____

Do you currently have a diagnosis? _____

Other professionals involved (e.g. physician, psychologist, psychiatrist, etc): _____

_____

Previous psychological/psychiatric treatment: _____

DEVELOPMENTAL / HEALTH FACTORS

Hospitalizations, accidents, or surgeries: _____

_____

Medications currently being taken, dosage, and reason: _____

_____

Problems with vision? Yes/ No Wears glasses? Yes/ No

Problems with hearing? Yes/ No _____

Motor Concerns (coordination, balance, fine/gross motor skills)? Yes/ No _____

_____

Speech/Language Concerns? Yes/No _____

_____

Has anything unusual or out of the ordinary occurred in development? _____

_____

FAMILY HISTORY

Marital status? Single Married Separated Divorced Widowed Remarried

How many years married? _____ How long have you been separated/divorced? _____

Children? Yes/No Ages_____

Who lives in the home? _____

_____

Family strengths: _____

Family challenges: _____

Briefly describe a typical evening in your household: _____

_____

_____

Describe family history of psychiatric/psychological, academic, legal and substance abuse problems? _____

_____

EDUCATIONAL/VOCATIONAL BACKGROUND

Education/Jobs

_____

_____

_____

_____

_____

_____

Describe employment difficulties: _____

_____

_____

When did these problems begin? _____

SOCIAL /EMOTIONAL DEVELOPMENT

Describe your temperament/mood: _____

How do you get along with peers?_____

Activities the client enjoys:_____

Describe any current social/emotional concerns? _____

_____

Behavioral/Emotional difficulties: _____

_____

Traumatic events experienced (e.g. death of someone close, abuse, divorce):_____

_____

Circle any of the following that you are currently experiencing:

Mood swings	sleep difficulties	nightmares
depression	anxiety	memory loss
suicidal ideation	dangerous behaviors	prefers to be alone
attention problems	poor appetite	aggression
restlessness	anger outbursts	excessive worry
motor/vocal tics	poor frustration tolerance	

What are your strengths? _____

_____

What are your weaknesses? _____

_____

ADDITIONAL INFORMATION

What are your expectations for coming to this office? _____

_____

Any additional information that would assist in understanding your difficulties? _____

_____

_____

Is there any other problem or question that you would like addressed or any other area in which you need assistance? _____

_____