Rachel Lacy, Psy.D., P.C.
1805 Herrington Rd., Building 2
Lawrenceville, GA 30043

ADULT QUESTIONNAIRE

Confidential

Information requested on this questionnaire will aid us in understanding your problems. We would appreciate you filling it out carefully and fully. Please feel free to add as much information as you want. If you wish, someone who knows you well may help you in filling out the form. You may use the backs of pages if necessary.

Name_____ Date_____

Address _____
(street) (city/state) (zip)

Social Security # _____Date of birth_____

Home phone # _____Business phone #_____

Age _____Sex _____Marital Status_____

Occupation_____Current Employer_____

Referred by _____Phone #_____

***In case of emergency, contact:*_____**

Relationship _____Phone #_____

Address_____
(street) (city/state) (zip)

Current living situation_____

Driving? _____Last time drove?_____

Describe the illness(es) or accident(s) that made, or may have made, a big change in your life and give the dates of their occurrence.

Accident/ Illness Date

_____

_____

_____

_____

Were you unconscious? _____How long?_____
_____

Is there a period of time for which you have no memory?

_____

How long? _____

Describe your physical health._____

_____

_____

Date of last physical exam _____

Physician(s):

Name	Type of Doctor	Address	Phone

List any prescribed medications you are presently taking. Include dosages and dates started.

Medication	Dosage	Times Taken Per Day	Date Started

List over-the-counter medications you take fairly often, including vitamins, supplements and herbal remedies.

_____

_____

_____

_____

Describe any other serious illness, hospitalizations, accidents or operations:

Date	Name of doctor or hospital	Location	Nature of Illness/ Surgery

Please indicate if you have had any history of the following:

__Alcoholism
__Anoxia or hypoxia
__Arteriosclerosis
__Cancer
__Cancer treatment
__Cerebral vascular disease
__Coronary dysfunction
__Cortisol deficiency
__Diabetes
__Gastrointestinal disorders
__Genital or urinary problems
__Headaches
__Head trauma
__HIV
__Hypertension
__Hypoglycemia
__Hyponatremia
__Hypoxemia
__Liver Disease
__Motor Difficulties
__Pernicious Anemia
__Porphyria
__Renal dialysis
__Respiratory problems
__Seizures
__Sleep apnea
__Substance abuse
__Syncope
__Systemic lupus erythematosus
__Toxic or heavy metal exposure
__Vascular disease
__Vertigo
__Vitamin deficiencies

Developmental History:
Problems or maternal use of drugs during pregnancy _____
_____
Place of birth_____ **Birth order**_____
Birth weight_____ **Problems during or after delivery**_____
_____

Developmental milestones: age walking_____ **age talking**_____ **age toileting**_____
Engaging peers_____ **Tolerating seperation**_____**playing cooperatively**_____

Childhood diseases or history of health problems: _____
_____
_____

Emotional or behavioral problems during childhood and adolescence:_____
_____
_____

History of learning disabilities_____
_____
_____

History of ADD/ ADHD:_____

History of physical, sexual, or emotional abuse/trauma
_____
_____
_____

History of head trauma _____
_____
_____

Please indicate if the following stressors are currently present in your life. Circle all that apply and describe the nature of the problem.

Financial difficulties _____
Sexual Difficulties _____
Loss of Friends _____
Conflicts with others_____
Work related difficulties_____
Recent problems with the law_____
Pending Litigation _____
Recent family conflict _____
Academic difficulties _____
Other_____

History of previous emotional or psychiatric difficulties:
_____
_____

History of suicidal ideation or behavior:_____
_____

History of psychiatric treatment:_____
_____
_____

History of hospitalizations for emotional problems:_____
_____

History of psychiatric medications:

Name of Medication	Date Started	Length of Time Taken	Effectiveness

Past alcohol and drug use:

Name of Substance	Age started	How Much?	How Often?	Heaviest Use?

Present alcohol and drug use:

Name of Substance	Age started	How Much?	How Often?	Heaviest Use?

Do you use tobacco products?____ What type?_____ How much per day?_____
Past use of tobacco: Age started_____ Heaviest use?_____
For how long?_____If stopped, when?_____

Do you use caffeine?_____ Coffee, tea, soda, or pills?_____ How much per day?_____

List all the people living in your current household. Note any adopted or step-children.

Name	Relationship	Age	Education	Occupation

List the people in your family of origin. Include parents and siblings. If deceased, note year of death and age at the time.

Name	Relationship	Age	Education	Occupation

List other members of your immediate family not previously listed. Include any previous marriages, and note any deaths.

Name	Relationship	Age	Location	Education	Occupation

Marital status_____ Number of years married _____
History of previous marriages _____
Previous and current marital difficulties _____
_____

Physical and emotional health of children _____
_____
Living status of children _____
Effects of children on patient _____
Current support system _____

Circle the physical or neurological problems that run in your family.

Arthritis	**Diabetes**	**Huntington's chorea**	**Stroke**	**Cancer**
Epilepsy	**Heart Disease**	**Bipolar Disorder**	**Depression**	**Schizophrenia**
Alzheimer Disease		**Highblood pressure**	**Thyroid Disorders**	

Other_____

Family alcohol and substance abuse history:

_____
_____
_____
_____

Family psychiatric history, illnesses and/or treatment:

_____
_____
_____
_____

Family criminal history:

_____
_____
_____

Patient's legal history: (If applicable)

Arrests_____**Type of criminal offense**_____
_____

Time served in jail_____
Time in probation_____
Prior history of litiagation_____
Prior history of disability claims_____
Current legal problems_____
Current court cases_____

Education history (beginning with High School)

School	**Dates**	**Location**	**Degree/ diploma**

Highest grade completed: _____
Reasons for leaving school or college:_____
Technical school training/ certificates obtained:_____
Describe any school related difficulties such as trouble learning to read, write, spell or do arithmetic; repeating a grade, or being placed in special education classes.

_____
_____
_____

History of conduct or behavioral problems:_____
_____
_____

What were your grades like in elementary school (please provide grades obtained)? Were they fairly consistent? If not, when did you do well and when did you do less well?_____
_____
_____

What were your grades like in high school? Were they fairly consistent? If not, when did you do well and when did you do less well?_____
_____

Extracurricular activities in school: _____
_____

Awards and achievements:_____
_____

What were your grade like in college or technical school? Were they fairly consistent? If not, when did you do well and when did you do less well?_____
_____

Extracurricular activities in college:_____
Awards and achievements: _____

Are you right-handed ?___ left-handed ?___ or ambidextrous?_____
(check one and explain if ambidextrous)

List anyone in your family of origin who was left-handed or ambidextrous._____
_____

Work history BEFORE illness or accident:

Job	Dates	Location	Duties	Reason for leaving

Work history AFTER illness or accident:

Job	Dates	Location	Duties	Reason for leaving

Longest held job:_____**History of job terminations:**_____
History of job promotions:_____
Job related goals:_____

Military service:
Branch and dates of service: _____
Jobs held within service: _____
Training received while in service:_____
Combat history: _____
Rank at discharge:_____ Type of discharge:_____
Service connected disabilities _____

What were your main hobbies and interests BEFORE the illness or accident?_____
_____
What are your main hobbies and interests AFTER the illness or accident?_____
_____

Cultural Background: Country of Birth: _____First language spoken:_____
Other languages spoken: _____ Preferred language: _____
Ethnic background of patients and family: _____
History of Discriminations: _____
_____
Religious background:_____ Church/ Temple/ Mosque attendance_____

In the next sections please describe yourself in regard to each of the following aspects of mental functioning behavior. Describe the situation before the accident or illness on the left and the recent or current on condition on the right. *If the condition is one you have experienced all of your life, then only complete the column on the left side of the page.*

Before the accident or illness		**Recently and currently**
	Concentration	
_____		_____
_____		_____
	Energy and activity level	
_____		_____
_____		_____
	Depression	
_____		_____
_____		_____
	Elation and other types of high mood	
_____		_____
_____		_____
	Sleep	
_____		_____
_____		_____
	Anger or Anger Control Problems	
_____		_____
_____		_____

Before the accident or illness		Recently and currently
	Agitation or Irritability	
	Appetite for food	
	Sexual behavior and sexual interest	
	Consumption of alcohol and other drugs	
	Hearing	
	Vision and other aspects of sight	
	Ability to find your way around - Spatial ability	
	Headaches	
	Pains other than in the head	
	Fatigue	
	Understanding what you hear	
	Finding words when you know what you want to say	
	Memory for things people say or things you need to do	

Before the accident or illness	**Recently and currently**
Imagery and memory for faces	
Reading	
Calculating - balancing check book	
Playing or listening to music	
Motor behavior - skillful activity	
Unusual sensations or strange experiences	
Ability to relax and experience pleasure	
Social behavior - being with people	
Ability to work or hold job	

Please use this space for additional information which you think would be helpful:

_____

_____

_____

_____

_____

_____

_____

_____

(signature) (date)

If another person assisted in completing this form, please enter appropriate information below.

Name _____ **Relationship to client**_____

Address_____**Phone**_____