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# ADULT CLINICAL QUESTIONNAIRE

Please answer the questions that follow as accurately and as completely as possible. We will review many items below later. This information will become part of your confidential record with our office. It will not be released without your written consent.

Name _____ Date of Birth _____ Age _____ Gender _____

Current Home Address _____ City _____ State _____ Zip _____

Where were you born? City: _____ State: _____ Phone_____ Is it okay to contact you at this number?: Yes No

May we leave a voice mail message at this number? Yes No. Do you have any special calling instructions for us?

_____ .

How did you learn of our services? _____

Primary Physician _____ Physician seen in what city _____

**CURRENT CONCERN/PROBLEM**

What is/are the primary reason(s) for you visit here today?

_____

_____

What do you hope we can do to help you?

_____

_____

For how long has this been a concern for you? _____

Did you have similar behavioral or emotional concerns or problems when you were younger?

_____

Have you been seen professionally in the past for similar concerns or problems? If so, did it help?

_____

What are you most worried might happen if things continue as they are now? _____

_____

**MEDICAL/PSYCHIATRIC**

Have you ever taken medicines to help with behavioral or emotional problems? Yes NO

Were these medicines beneficial to you in the past in that you functioned or felt better/were stable Yes NO

Please list your **current** prescribed Medications:

| Name | Dose | How many times per day? |
|---|---|---|
| | | |
| | | |
| | | |



Are you presently under the care of a psychiatrist, Psychologist or other Mental Health Professional? Yes No If so, why?

_____

How would you describe your current mood? (happy, sad, angry, …) _____

How would you describe your current energy level? (good, low, high, very high) _____

How would you describe your appetite? (low, about average, voracious, …) _____

Approximately how many hours of sleep do you get each night? _____

Have you ever been a voluntary or involuntary patient in a psychiatric hospital? Yes NO

If you have been a patient please tell us more below?

| Facility Name | Approx Month and Year | Length of Stay | Reason for Admission |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

Have you ever seriously considered suicide or felt like seriously harming someone else? Yes No If yes, please explain:

_____

_____

Do you have any plan of taking your life at this time? Yes No

Do you have any plan of taking the life of another at this time? Yes No

- At this time do you have any problems with any of the following (Circle those that apply): excessive overspending, food binging, yelling/threatening, risk taking/endangering self or others, hitting, shoving, choking, or hurting others, stealing, sleeping excessively, staying awake most nights or several nights in a row, seeing things that others do not see, hearing things that others do not hear, frequent episodes of trembling, shaking or sweating, excessive worrying, sensations of shortness of breath and dizziness, marked decrease in your interest to socialize, concentration.
- Are any of the above circled problems causing you significant difficulties at work or at school? Yes No
- If yes, how? _____

How would you describe your current health: ___excellent ___good ___fair ___poor

When were you last seen by your primary physician? _____ Why? _____

Have you ever had a significant injury to your head? Yes No If yes, what year? _____
Did you lose consciousness? Yes No Were you seen at a local ER or hospital or Urgent Care Facility? Yes No

Please list any medical hospitalizations or surgeries you have required and tell us what year

_____
_____
_____



**RELATIONSHIPS/FAMILY**

Marital Status: Married/ Divorced/ Single/Widowed/Separated Name of Spouse or Partner _____ Are you presently In litigation with your former spouse? Yes No

Do you have children? Yes No If yes, what are their ages? _____

Who lives in your household? _____

**WORK**

What is your current Occupation _____ Employer _____ Do you like your job: Yes No Its OKAY

On a scale of 1-10 (10 = very stressful) how stressful is your job: _____

If you are not working now, what was the last paying job you had? _____
If not presently working, how are you able to financially support yourself? _____

**DRUGS/ALCOHOL/SUBSTANCES**

Do you now or have you ever had any problems managing your consumption or use of alcohol, pain medications or other prescribed medications or illicit drugs such as marijuana, cocaine, methamphetamine, "spice", ……? Yes No

If yes, please explain _____
_____

Have others, such as friends or family, told you that you have a problem with your use? Yes NO

**FAMILY HISTORY**

In your biological family are you aware of a history of any of the following (please **circle** those that apply)

| | | | |
|---|---|---|---|
| Schizophrenia | Obsessive-Compulsive Disorder<br><br>Panic | Depression<br><br>Suicide<br><br>Bipolar Disorder | Learning Disorder<br><br>ADHD |
| Mental Retardation | Substance Abuse | Autism | Hallucinations |
| Anxiety | Speech/Communication | Other: | Fragile X, Downs,… other genetic disorder |

**EDUCATION**

How far did you get in school" _____ grade. Did you ever repeat a grade? Yes No

Were you ever in Special Education Classes? Yes NO If you were in Special Ed, why?

_____

Were you ever in accelerated or Advanced Placement classes? Yes No

Circle your highest degree earned: High School Diploma, GED, AOD, Bachelors, Masters, Doctorate, Other _____



| Thinking back at your school experiences did you: | YES | NO |
|---|---|---|
| Often leave things unfinished | | |
| Have a very difficult time getting started with a task (you procrastinated terribly) | | |
| Have more difficulty sitting still than your peers | | |
| Get distracted easily by things you saw or heard | | |
| Have difficulty concentrating on your reading or homework | | |
| Frequently lose or forget to do your work or lose your personal belongings | | |
| Often act without thinking or be described as "impulsive" | | |
| Often described by others as forgetful and in need of frequent reminders | | |

Did you get in trouble during your childhood/teenage years for any of the following? (Check those that apply)

| Cheating | stealing | fighting | setting fires | using drugs or alcohol | running away from school | truancy |
|---|---|---|---|---|---|---|
| | | | | | | |

**LEGAL**

Have you ever been convicted of a Felony or Misdemeanor in this or any other state? Yes No. If yes, what were the charges? _____ Have you ever spent time in jail or prison? Yes No. If yes, when did you parole? _____ Are you now on probation Yes No

**DAILY ACTIVITIES** (Please circle the activities you do or feel you could do if needed on a regular basis)

Drive a car take a bus dress yourself dust shop for groceries pay bills manage your own money cook do your laundry go out alone socialize with friends or family dust vacuum

**HOBBIES**

Tell us what you like to do: _____

**MILITARY**

Did you serve in the Military? Yes No If yes, what branch? _____ How long? _____ Did you deploy to a combat zone? Yes No If yes, where _____ For how long total? _____ How many tours have you completed ? _____. What is your current rank or highest rank attained _____ If discharged, was your discharge: Honorable General Dishonorable Other _____ While in the Military, did you sustain any significant injuries to your head? Yes No. If yes, please explain:

_____ Do you think that your military experiences have significantly and negatively impacted your ability to function now at home work or otherwise Yes No. If yes, please explain: _____

_____
_____

Consider this space yours to note anything you feel is important and has not been addressed



_____
_____
_____
_____

**Thank you for completing this form. We know it is rather long and we appreciate your effort!**