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adult/adolescent questionnaire

Name: _____ Date of Birth: _____

presenting problem/psychiatric history

Please briefly explain the reason(s) for seeking evaluation/treatment at this time:

_____

_____

Have you experienced or been treated for similar, or other, emotional/ behavioral/chemical dependency difficulties in the past? Please include past provider's names.

_____

_____

_____

_____

family history

Briefly describe the family situation you grew up in, names, ages, health status of parents and siblings.

_____

_____

_____

_____

social history

Briefly describe your relationships with others your own age during your childhood, adolescence, and early adulthood. Date(s) of marriages, divorces? List names and ages of spouses, children and health status of each.

_____

_____

_____

_____

EDUCATIONAL HISTORY

Summarize your educational history below (including the highest grade completed in school, any specialized training you have received, and any future educational plans).

_____

_____

_____

OCCUPATIONAL HISTORY

Summarize your occupational history below (specify how satisfied you are with your current position and any future occupational plans).

_____

_____

_____

MEDICAL HISTORY

Please describe any significant current or past medical problems (please list any current medications you may be taking).

_____

_____

_____

DRUG/ALCOHOL HISTORY

Please indicate your present or past use of alcohol, marijuana, stimulants, opiods,or any other non-prescribed substance.

Type/Frequency/amount:

_____

_____

_____

_SYMPTOMS/STRESSORS

Please circle any traits that describe you:

Excessive anxiety	Excessive worry	Excessive self-criticism
Excessive depression	Suicidal thoughts	Low energy/motivation
Sleep problems	Appetite problems	Weight gain or loss
Social isolation	Anti-social behavior	Excessive anger/aggression

Legal problems	Homicidal urges	Bizarre/unusual experiences
Confused thinking	Mistrust of others	Drug/alcohol problems
Sexual problems	Recent divorce	Recent relationship breakup
Recent death of loved one	Recent job loss	Other job-related problems
Serious financial problems	Marital problems	Other relationship problems
Past/current abuse	Other traumas	

SOCIAL SUPPORT SYSTEM

Who are the most important people in your life at this time?

_____

_____

STRENGTHS

What do you consider to be the most positive things about yourself and your current life situation?

_____

_____

OTHER INFORMATION

Please list any other information you feel may be important or helpful.

_____

_____

Signature: _____ Date: _____