(949)716-5150

ADULT HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to obtain information, which will enable your therapist to understand you and your situation better. It will assist him/her in developing a treatment plan, which considers your needs, as well as your background. Case records, including this form are kept strictly confidential, except in court action when confidentiality is waived (i.e. 730 evaluations).

If you do not wish to answer a question, please write "do not care to answer." If a question does not apply to you, please write N/A or skip the question. If you would like to discuss a particular question in more detail during an office visit, please indicate your desire in your response.

GENERAL INFORMATION

Name: _____ **Date:** _____

Complete Address: _____

Phone Number: _____ **Birthdate:** _____ **Age:** _____

Occupation: _____ **Height:** _____ **Weight:** _____ **Religion:** _____

Physician Name: _____ **Physician's Phone:** _____

Physician's Address: _____ **Marital Status:** _____

Who do you live with? Please list names, ages, occupations, or the grade they attend:

NAME	AGE	OCCUPATION/GRADE

CLINICAL INFORMATION

Please state the nature of your problems, including approximately when they began:

_____

_____

_____

If you've worked with other professionals in the past, please list their names, as well as the length of time in treatment.

_____

_____

_____

PLEASE CIRCLE ANY OF THE FOLLOWING THAT APPLY TO YOU:

Headaches	Dizziness	Fainting Spells	Palpitations	Stomach Problems
Overeating	Fatigue	Lack of Appetite	Insomnia	Bowel Disturbances
Tremors	Depression	Suicidal Thoughts	Panic Feelings	Unable to Enjoy Life
Workaholic	Shyness	Sexual Problems	Crying Often	Unable to Relax
Loneliness	Tension	Inferiority	Nightmares	Can't Make Decision
Aggression	Fight Often	Quick to Anger	$$ Problems	Can't Make Friends

Other: _____

Use of alcoholic beverages: Never Rarely Occasionally Frequently

When did you start drinking? Age _____ Previous Treatment: _____

Do you smoke cigarettes? Yes _____ No _____ If so, how much? _____ How long? _____

Are you taking prescription medications? Please list names of medicines and dosage:

_____

_____

Do you use non-prescription drugs? Yes ____ No _____ If yes, please indicate the following:

Type used _____	How Often:	Rarely	Occasionally	Frequently
Type used _____	How Often:	Rarely	Occasionally	Frequently
Type used _____	How Often:	Rarely	Occasionally	Frequently

DEVELOPMENTAL HISTORY

Date and place of birth: _____

If applicable, were pregnancies and deliveries normal? Please list any complications/illnesses:

_____

Health during childhood:

_____

Health during adolescence:

_____

PLEASE CIRCLE ANY OF THESE THAT APPLIED TO YOUR CHILDHOOD:

Night Terrors	**Bedwetting**	**Sleepwalking**	**Thumb Sucking**
Nail Biting	**School Problems**	**Unhappy Childhood**	**Stammering/Stuttering**
Fears	**Sexual Abuse from a Stranger**		**Physical Abuse**
Stormy Teens	**Sexual Abuse from a Family Member**		**Trouble with the Law**
Drug/Alcohol Problems			

List any accidents, hospitalizations, or surgeries you have undergone:

_____

_____

When did you have your last physical exam? Results?

_____

_____

When was the last time you felt both physically and emotionally well for at least two years:

_____

_____

INTERESTS

Please list your present interests, hobbies, activities, organizations, etc.:

_____

_____

How is most of your time spent?

_____

_____

EDUCATIONAL HISTORY

Last grade or year in school completed:

Degrees earned (please give dates, if possible):

Please describe your scholastic abilities and disabilities:

Please describe your relationships with schoolmates:

Were you bullied at school?

Did you/do you make friends easily?

OCCUPATIONAL HISTORY

At what age did you start working?

List in order the jobs you have had and reasons for leaving (most recent first):

1. _____
2. _____
3. _____

Do you like your job/career? _____ If not, how are you dissatisfied:

_____

Approximately how much to you (and your spouse) earn annually? _____

What are your present ambitions and aspirations job wise?

SEXUAL HISTORY

Parental attitudes toward sex (was there sex education or discussion in the home)?

When and how did you first obtain your knowledge about sex?

When did you first become aware of your own sexual impulses?

Have you experienced any anxieties or feelings of guilt arising from sex?

Did you have a sexually active adolescence and are you sexually active now?

If applicable, menstrual information: Age started: _____ Are you regular? _____

Duration: _____ Do you experience mood swings? _____Do you experience pain? _____

MARITAL HISTORY

Are you presently married? Yes _____ No _____ If so, for how long: _____

Are you currently living with your spouse? Yes _____ No _____

How long have you known your spouse/partner? _____

How do you get along with your present in-laws (parents, brothers/sisters in-law)?

_____

_____

Describe your partner's personality (please include some positive and negative features):

_____

_____

_____

In what areas are you most compatible?

_____

_____

In what areas are you least compatible?

_____

_____

Please list the names of your children, from oldest to youngest, as well as some comments about them:

NAME	AGE	SEX	COMMENTS

Please indicate if children are from previous marriages.

_____

_____

_____

FAMILY HISTORY

PARENTS

Father's Name: _____ **Occupation:** _____

Age: _____ **Health:** _____ **If deceased, cause of death:** _____

Mother's Name: _____ **Occupation:** _____

Age: _____ **Health:** _____ **If deceased, cause of death:** _____

Describe your father's attitude toward you (past and present):

_____

_____

_____

Describe your mother's attitude toward you (past and present):

_____

_____

_____

In what ways were you disciplined by your parents as a child?

_____

_____

Were you able to confide in your parents?

_____

_____

SIBLINGS

Sibling's Name: _____ **Occupation:** _____

Age: _____ **Place of Residence:** _____ **If deceased, cause of death:** _____

Sibling's Name: _____ **Occupation:** _____

Age: _____ **Place of Residence:** _____ **If deceased, cause of death:** _____

Sibling's Name: _____ **Occupation:** _____

Age: _____ **Place of Residence:** _____ **If deceased, cause of death:** _____

Sibling's Name: _____ **Occupation:** _____

Age: _____ **Place of Residence:** _____ **If deceased, cause of death:** _____

Does any member of your family suffer from alcoholism, epilepsy, bipolar disorder, depression, schizophrenia, or any other form of mental disorder or medical problems?

Do you recall any fearful or distressing experiences not previously mentioned? These may have occurred in childhood or as an adult. Please indicate them here:

SELF DESCRIPTION

In what kinds of situations are you most likely to lose self-control? How and when does this occur? If possible, please cite specific instances:

In what kinds of situations are you best able to maintain self-control?

Give a description of yourself:

Thank you for taking the time and making the effort to complete these forms.

A:/adulthistoryquestionnaire