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Adult Client History Questionnaire

Name: Today's Date:

Date of Birth: Age:

Referred By:

What brought you in today? _____

Please Check All Symptoms That You Are Currently Experiencing:

Sad Mood	Racing Thoughts	Panic Attacks	Excessive Dieting
Low Energy/Fatigue	Concentration/Memory Difficulties	Fear of Leaving the House	Focused on Body Weight or Image
Hopelessness	Increased/Decreased Sexual Interest	Fear of Driving	Change in Weight
Guilt	Decreased Appetite	Fear of Specific Situations/Things	History of Trauma/Victim of Abuse
Worthlessness	Increased Appetite	Fear of Being in Public	Offender of Abuse
Crying Spells	Difficulty Falling Asleep	Upsetting Thoughts	Hearing Voices Others Do Not
Decreased Motivation	Excessive Sleeping	Repetitive Thoughts or Behaviors	Seeing Images Others Do Not
Loss of Interest in Usual Activities	Early Morning Waking	Excessively Orderly or Perfectionistic	Bizarre Ideas
Irritability	Suicidal Thoughts	Periods of "Lost" Time	Recent Upsetting Change or Loss
Hyperactivity	Thoughts of Harming Others	Excessive Anger / Aggressiveness	Alcohol Abuse
Impulsiveness	Self Harm/Cutting	Difficulty Trusting Others	Drug Abuse
Elevated Mood	Anxious/Worried	Binge Eating / Purging	Overuse of Prescription Medication

Current Medications: Please list all medications that you are taking.
Include psychiatric and medical medications.

Medication	**Dose** *(mg, units,mL, etc)*
1.	
2.	
3.	
4.	
5.	
6.	

Medication History: Please list all medication that you have been prescribed in the past for a mental health issue, i.e. anxiety, depression, ADHD.

Medication	**Dose** *(mg, units,mL, etc)*	**Reason for Discontinuation**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Have you experienced a head injury? If so, please explain what happened, your age, and if you were **unconscious:**_____

_____

Primary Care Physician:_____

_____

Clinic Address and Phone Number:_____

_____

Current Health Problems? _____

_____

_____

_____

Previous Surgeries and/or Hospitalizations? If so please put approximate dates. _____

_____

_____

_____

Past Psychiatric History
Have you ever seen a psychiatrist? If so, please provide information about providers, dates, and treatment rendered.

_____
_____
_____

Have you ever seen a therapist (*i.e. LMHC, LCSW, LMFT*)?

_____
_____
_____
_____

Has anyone ever given you any diagnosis? If so, what, who diagnosed you and when?

_____
_____
_____

Social History:

Marital Status: Single Married Divorced Widowed Partnered

Have you had any previous marriages? _____

Lives With (Name, Age, and Relation to Yourself):

_____
_____
_____

Do you have any children that do not live in your home? Provide name and age._____
_____
_____

Occupation and Employment (*specialty, where you work, and how long*):

_____
_____

Arrest History or Pending Legal Issues (*i.e. divorce, disability, bankruptcy, etc)*:

_____
_____
_____
_____

Family History: Please indicate if there is a family history of the following conditions and who is affected with the condition.

Anxiety	Heart disease
Depression	Sudden cardiac death
Bipolar disorder	Cancer
ADHD	Alcoholism
Autism	Drug abuse
Eating Disorders	Thyroid problems
Learning disabilities	Seizures
Other psychiatric conditions?	Other medical conditions?

Any other concerns not yet addressed? _____

_____

_____

_____

_____