Integrity Psychological and Counseling

Adult Questionnaire

Today's Date: _____

Name: _____ Age: _____ ☐ Male ☐ Female Date of Birth: _____

Who referred you? _____

Problems for which you are seeking therapy: _____

_____

Changes you hope to happen in treatment? _____

Treatment History

Have you ever been hospitalized for mental health or alcohol/substance abuse problems? ☐ No ☐ Yes

If yes, please specify facility, approximate dates, and reason: _____

_____

Seen a therapist or counselor? ☐ No ☐ Yes If yes, specify: _____

Does anyone in your family have a history of mental health problems or addictions? ☐ No ☐ Yes

If yes, who and a brief description of the problem: _____

_____

Do you use any of the following? ☐ Alcohol ☐ Tobacco ☐ Caffeine ☐ Drugs (other than prescribed) ☐ No

If yes, for how long and in what amounts: _____

_____

_____

Have you ever felt the need to reduce or limit the amount of alcohol or drugs you use? ☐ No ☐ Yes
Have others ever expressed concern about your level of use of its effects on you? ☐ No ☐ Yes
Have you ever used drugs or alcohol as an "eye-opener" in the morning? ☐ No ☐ Yes
Have you ever had guilt about your drinking or drug use? ☐ No ☐ Yes

Have you had thoughts of death or of harming yourself within the past month? ☐No ☐ Yes How recently? _____
Do you currently have thoughts of death? ☐ No ☐ Yes
Have you ever attempted suicide? ☐ No ☐ Yes
If yes, when and how: _____

_____

Do you have current thoughts of harming someone else? ☐ No ☐ Yes

If yes, whom: _____

Have you ever experienced hallucinations? ☐ No ☐ Yes If yes, describe: _____

_____

Medical History

Please list specific medical conditions, procedures, hospitalizations or operations that you have had in the past: _____

_____

Please list any current physical problems or illness that significantly affect your health: _____

_____

Please list physicians who are currently treating you: _____ Date of last exam: _____

Please list any current medications (including over the counter & hers/supplements) you are taking: _____

_____

_____

Previous psychiatric medications: _____

_____

Social History

Relationship status: □ Single □ Married For how long? _____ □ Divorced □ Widowed □ Separated

Number of marriages? _____

People living in the same home with you:

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any minor children not living with you? □ No □ Yes If yes, please specify: _____

_____

Were you raised by your biological parents? □ Yes □ No If no, by whom_____

Are they living? □ Yes □ No If no, cause and age at time of death: _____

Please list name and ages of your brothers and sisters: _____

_____

Education: □ Some high school □ GED graduate □ High School □ Some college □ College graduate □ Post graduate

If currently working, what is your occupation? _____ How long? _____

Which of the following legal actions has happened to you? □ None □ Probation □ Parole □ Child Custody □ DUI

Current charges ? _____

Current legal situations?_____

Have you experienced emotional, physical abuse, sexual abuse, rape, or domestic violence? □ No □ Yes

If yes, please specify (if you prefer you may wait and discuss with your therapist): _____

_____

_____

Please ask me about:

□ Mood
□ Fear
□ Sleep patterns
□ Unusual experience
□ Judgment and decision making
□ Ability to feel close and safe with others
□ Risky behavior
□ Sexuality or sex-related concerns
□ Childhood issues
□ Spiritual beliefs
□ Anxiety
□ Obsessive/Compulsive thoughts or actions
□ Anger
□ Troublesome thoughts
□ Mental abilities/changes
□ Marriage or relationships
□ Abusive relationship
□ Alcohol or substance abuse
□ Body image and/or eating
□ Financial situation

Signature: _____ Date: _____