History Questionnaire- Adult

Please take time to fill out this form. This will aid greatly in providing appropriate therapeutic care for you.

DOB
Name: ________________________________ : ________________________________

BIRTH HISTORY
Did your mother do any of the following when she was pregnant with you?

☐ Yes ☐ No   Drink Alcohol
☐ Yes ☐ No   Smoke Cigarettes
☐ Yes ☐ No   Was Depressed

Describe if yes is marked for any of the above:

Birth Weight lbs oz
☐ Yes ☐ No   Any complications with labor or delivery?

Describe if yes:

DEVELOPMENTAL HISTORY

☐ Yes ☐ No   Did you have any problems (physical, emotional, etc.) in your early childhood?

Describe if yes:

☐ Yes ☐ No   Did you experience any developmental delays as a child?

Describe if yes:

List any childhood illnesses, serious accidents, or hospitalizations:
Age at time of incident:   Describe incident:

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Age at time of incident:   Describe incident:

☐ Yes ☐ No   History of head injury or loss of consciousness   Describe:

☐ Yes ☐ No   History of seizures   Describe:

☐ Yes ☐ No   Allergies   Describe:

☐ Yes ☐ No   Current health problems   Describe:

☐ Yes ☐ No   Current infectious disease(s)   Describe:

☐ Yes ☐ No   Current medications   Describe:

Name of medications:   Dose/frequency:

Additional comments: ____________________________________________

___________________________________________
List any other people living in your home at this time:

Name: ____________________ Age: _____ Relationship to you: __________________

Name: ____________________ Age: _____ Relationship to you: __________________

Name: ____________________ Age: _____ Relationship to you: __________________

Name: ____________________ Age: _____ Relationship to you: __________________

Name: ____________________ Age: _____ Relationship to you: __________________

List other important family members or relatives living outside the home:

Name: ____________________ Age: _____ Relationship to you: __________________

Name: ____________________ Age: _____ Relationship to you: __________________

Name: ____________________ Age: _____ Relationship to you: __________________

Name: ____________________ Age: _____ Relationship to you: __________________

Name: ____________________ Age: _____ Relationship to you: __________________

Which of the following describes your current living situation?

- [ ] Rent apartment
- [ ] Rent house
- [ ] Own house
- [ ] Foster care
- [ ] Condominium
- [ ] Shelter
- [ ] Homeless
- [ ] Group home
- [ ] Residential treatment

What is the primary language spoken in your home? ________________________________

Current Employer: ________________________________

Job Title: ________________________________

How long: ________________________________

FAMILY HISTORY

List the places you have lived for the past five years:

Where: ____________________________

With whom: ____________________________

Dates (from-to): ____________________________

1. ____________________________

2. ____________________________

3. ____________________________

4. ____________________________

5. ____________________________

Have you ever experienced any of the following?

- [ ] Yes  [ ] No  Physical Abuse  Age/Describe: ____________________________

- [ ] Yes  [ ] No  Sexual Abuse  Age/Describe: ____________________________

- [ ] Yes  [ ] No  Assault  Age/Describe: ____________________________

- [ ] Yes  [ ] No  Death of a parent  Age/Describe: ____________________________

- [ ] Yes  [ ] No  Death of a relative  Age/Describe: ____________________________

- [ ] Yes  [ ] No  Death of a friend  Age/Describe: ____________________________

- [ ] Yes  [ ] No  Parental separation  Age/Describe: ____________________________

Additional Information:

______________________________

______________________________

______________________________

______________________________
Please describe on both parents’ side of the family any history of mental illness, suicide, legal problems, chemical abuse or dependency and physical/sexual abuse. If it is someone else, describe his or her relationship to you (i.e. paternal uncle- alcoholic, mother- depression, etc):

**Mother’s side of the family:**

- [ ] Yes  [ ] No    Alcohol abuse    If yes, whom? ____________________________
- [ ] Yes  [ ] No    Substance abuse    If yes, whom? ____________________________
- [ ] Yes  [ ] No    Mental Health problems    If yes, whom? ____________________________
- [ ] Yes  [ ] No    Physical abuse    If yes, whom? ____________________________
- [ ] Yes  [ ] No    Sexual abuse    If yes, whom? ____________________________

**Father’s side of the family:**

- [ ] Yes  [ ] No    Alcohol abuse    If yes, whom? ____________________________
- [ ] Yes  [ ] No    Substance abuse    If yes, whom? ____________________________
- [ ] Yes  [ ] No    Mental Health problems    If yes, whom? ____________________________
- [ ] Yes  [ ] No    Physical abuse    If yes, whom? ____________________________
- [ ] Yes  [ ] No    Sexual abuse    If yes, whom? ____________________________

**Other issues currently affecting family members:**

- [ ] Yes  [ ] No    Health problems    If yes, describe: ____________________________
- [ ] Yes  [ ] No    Disabilities    If yes, describe: ____________________________
- [ ] Yes  [ ] No    Legal issues    If yes, describe: ____________________________
- [ ] Yes  [ ] No    Financial concerns    If yes, describe: ____________________________

**HEALTH/MEDICAL**

Describe yourself in the following areas:

**Sleeping habits:**

__________________________________________

**Eating habits:**

__________________________________________

**Energy level:**

__________________________________________

- [ ] Yes  [ ] No    Do you or anyone living with you have an infectious disease?    If yes, what? ____________________________

**CHEMICAL HEALTH**

- [ ] Yes  [ ] No    Have you ever had a chemical health assessment done?    If yes, when? ____________________________

- [ ] Yes  [ ] No    Have you ever had any chemical dependency treatment?    If yes, when? ____________________________

Describe your use of drugs or alcohol at this time:

- [ ] Yes  [ ] No    Cigarettes    Describe: ____________________________
- [ ] Yes  [ ] No    Alcohol    Describe: ____________________________
- [ ] Yes  [ ] No    Marijuana    Describe: ____________________________
- [ ] Yes  [ ] No    Inhalants    Describe: ____________________________
- [ ] Yes  [ ] No    Methamphetamines    Describe: ____________________________
- [ ] Yes  [ ] No    Cocaine/Crack    Describe: ____________________________
- [ ] Yes  [ ] No    Acid/LSD    Describe: ____________________________
- [ ] Yes  [ ] No    Other    Describe: ____________________________
- [ ] Yes  [ ] No    Previous chemical use problems    Describe: ____________________________
Describe your spouse/partner’s use of drugs or alcohol at this time: (if applicable)

☐ Yes ☐ No  Cigarettes  Describe: ________________________________

☐ Yes ☐ No  Alcohol  Describe: ________________________________

☐ Yes ☐ No  Marijuana  Describe: ________________________________

☐ Yes ☐ No  Inhalants  Describe: ________________________________

☐ Yes ☐ No  Methamphetamines  Describe: ________________________________

☐ Yes ☐ No  Cocaine/Crack  Describe: ________________________________

☐ Yes ☐ No  Acid/LSD  Describe: ________________________________

☐ Yes ☐ No  Other  Describe: ________________________________

☐ Yes ☐ No  Previous chemical use problems  Describe: ________________________________

☐ Yes ☐ No  Previous chemical dependency treatment: Describe: ________________________________

SCHOOL

Highest grade level completed: ____________________________________________

Describe what school was like for you: ______________________________________

________________________________________________________________________

________________________________________________________________________

Please list any other stressors that may be affecting you or your family at this time:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

SUPPORTIVE FACTORS

List any previous mental health services you have received:

<table>
<thead>
<tr>
<th>Clinic Name:</th>
<th>Therapist Name:</th>
<th>Dates:</th>
<th>Was it helpful?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
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<tr>
<td>3.</td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
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<tr>
<td>4.</td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

☐ Yes ☐ No  Do you have a probation officer?

☐ Yes ☐ No  Are you involved with a county Social Worker?

☐ Yes ☐ No  Do you have any other service providers?

Describe: ____________________________________________

Who are the people or services that you find supportive to you and your family (i.e. church, relatives)? Please be specific.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Describe the role of religious and/or spiritual influences on your family:

________________________________________________________________________

________________________________________________________________________

Describe any extracurricular activities you have or recreational hobbies you participate in:

________________________________________________________________________

________________________________________________________________________
Please check any areas that you may be concerned about:

- Depression
- Anxiety
- Gambling too much
- Weight Loss
- Learning Difficulties
- Chemical Use
- Fighting
- Stealing
- Violence
- Crying a lot
- Physical Abuse
- Nightmares
- Strange Behaviors
- Promiscuity
- Hyperactivity
- Lack of Friends
- Panic Attacks
- Physical Problems with No Known Medical Cause
- Sexual Abuse
- Obsessive Behaviors
- Obsessive Thoughts
- Excessive Worrying
- Paranoia
- Suicidal thoughts/plans
- Perfectionist
- Avoid Others
- Self Injurious Behavior
- Gender Confusion
- Destroy Things
- Odd beliefs
- Mood Changes
- Can’t Pay Attention
- Fire Setting

Use this space to elaborate about anything you mentioned above that you are concerned about:

**YOUR STRENGTHS (Check all that apply)**

- Stay Active
- Independent
- Helpful
- Share with Others
- Athletic
- Good Health
- Employed
- Positive Outlook
- Easy Going
- Maintain Friends
- A Leader
- Liked by Others
- Honest
- Attend school/Work Regularly
- Spiritual
- Intelligent
- Hard Working
- Have a hobby
- Structure Time Well
- Volunteers
- Cope with problems well
- Humorous
- Caring
- Playful
- Artistic
- Responsible
- Positive view of the world

**FAMILY STRENGTHS (Check all that apply)**

- Partner Employed
- Clear Rules at Home
- Sense of Humor
- Knows Child’s Friends
- Consistent Parenting
- Strong Ethnic/Cultural Identity
- Go on Vacations Together
- Relatives Involved with Child
- Good Support Network
- Volunteer in Community
- Parents Get Along
- Know How Child is Doing at School
- Attend Church
- Often Eat Supper Together
- Do Activities Together
- Involved at Child’s School
- Help Children with Problems
- Know Parents of Child’s Friends
- Able to Show Affection
- Children have Jobs in the Home
- Good Communication
- Resilient
- Caring

What would you like to see come out of services for yourself?

Is there any other information that would be helpful to know in helping you?

COMPLETED BY: ___________________________ DATE: ________________