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Comprehensive Adult Questionnaire

Name:_____ **Date:** _____

Presenting Problem

What are the main problems or symptoms that caused you to seek help now? _____

_____

_____

Describe any stresses in your life that may have contributed to the problem: _____

_____

_____

Describe the history of the problem from its onset until now: _____

_____

_____

Have you had a similar problem in the past? __ Yes __ No If so, please describe the episodes and the dates they occurred.

_____

_____

Were you treated for this problem? __Yes __No If so, please describe the treatment you received.

_____

_____

Has this problem caused you to experience any decrease in your ability to function in the following areas? If so, please describe:
School performance: _____

Work performance: _____

Relationship with spouse/significant other: _____

Functioning as a parent: _____

Social life: _____

Ability to manage chores at home: _____

Medical History

Please list all medications you are currently taking:

Prescription Medication	Dose	Start Date (MMYY)

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Please list any health problems: _____

_____

Mental Health History

Please list any Psychiatrist/Psychologist/Therapist you have seen previously:

Name	Dates Seen	Reason	Medications Prescribed

Have you ever attempted suicide? __Yes __No If yes, please describe the nature of the event and the date(s) of occurrence. _____

_____

Please list any blood relatives who have any history of mental or emotional problems (e.g. depression, manic depression, alcoholism, drug abuse, suicide, schizophrenia, anxiety problems, eating disorders, Attention Deficit Disorder, etc.)

Relative	**Problem**

Substance Use:

Do you use any of the following?

Substance	**Yes**	**No**	**Amount**	**Frequency:**	**Daily**	**Weekly**	**Date last used**
Tobacco	__	__	_____		__	__	_____
Caffeine	__	__	_____		__	__	_____
Alcohol	__	__	_____		__	__	_____
Marijuana	__	__	_____		__	__	_____
Cocaine	__	__	_____		__	__	_____
Amphetamines	__	__	_____		__	__	_____
LSD	__	__	_____		__	__	_____
Heroin	__	__	_____		__	__	_____
Pain Killers	__	__	_____		__	__	_____
IV Drug Use	__	__	_____		__	__	_____

Have you ever felt that you were abusing drugs or alcohol? __ Yes __No If so, please describe when and the nature of the problem. _____

_____

Have you tried to stop drinking? __ Yes __ No If yes, what was the outcome? _____

_____

Have you ever attended AA? __ Past __ Current If yes, do you have a sponsor and how often do you attend meetings? _____

Have you ever attended NA? __ Past __ Current If yes, do you have a sponsor and how often do you attend meetings? _____

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Family/Social History

Where were you born and raised? _____

Please list your siblings and their current ages: _____

_____

Are you close to your siblings? _____

How would you describe your relationship with your father? _____

_____

How would you describe your relationship with your mother? _____

_____

Describe your childhood: _____

_____

Were your parents divorced? __ Yes __ No If yes, how old were you? _____

With whom did you live after the divorce? _____

Did your mother remarry? __ Yes __ No Did your father remarry? __ Yes __ No

What was your relationship like with the stepparent(s)? _____

_____

Were you ever subjected to any type of abuse (emotional, physical, sexual)? __ Yes __ No

If yes, please describe the events and ages the abuse occurred. _____

_____

Have you lost a close family member or friend? __ Yes __ No Who? _____

When? _____

Educational History

Did you complete high school? __ Yes __ No

What kind of grades did you receive in school? _____

How did you get along with your peers? _____

How did you get along with your teachers? _____

Did you attend college? __ Yes __ No

Where? _____ Degree? _____

Occupational History

Are you currently working? __ Yes __ No What is your occupation? _____

What is your current position? _____

Where do you work? _____ How long have you been there? _____

Are you satisfied with your job? __Yes __ No If no, explain: _____

Describe any current job stresses you may be experiencing: _____

_____

How well do you get along with your co-workers? _____

How well do you get along with your supervisors? _____

List your last two jobs and how long you worked there: _____

_____

Relationship History

Are you currently __ Single __ Married __ Divorced __ Widowed __ Living Together

How long? _____ What is your sexual orientation? _____

Describe your relationship with your spouse or significant other: _____

_____

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List any stresses or problems in your relationship: _____

_____

If married, what is your spouse's occupation? _____

Have you been married before (or in a long-term committed relationship)? __ Yes __ No

How many times? _____ How long did these relationships last? _____

Please describe the reason for the break-up or divorce: _____

If you have children, what are their names and ages? _____

_____

Describe any problems you may be experiencing with your children: _____

_____

What is your religious preference? _____

How often do you attend religious services? _____ Where? _____

Any hobbies? _____

Is there any other important information about you that has not been covered, which you feel the therapist should know? _____

*****Please complete the attached symptom checklist*****

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Symptom Checklist

Check all that apply. Then circle items that are especially bothersome to you.

Recent Past

1. Please check any of the following which may have been particularly stressful to you:

___ ___ Job related stress
___ ___ Marital conflict
___ ___ Death or loss of loved one
___ ___ Move to a new place and losing contact with friends or family
___ ___ Conflict with children
___ ___ Children with behavior problems
___ ___ Conflict with parents or extended family
___ ___ Feeling stress due to recalling memories of trauma or stress in my life
___ ___ Family member with an alcohol or drug problem
___ ___ Being abused by someone
___ ___ Financial pressure

2. Any of the following symptoms for most of the day, nearly every day, for periods longer than several days at a time:

___ ___ Depressed or sad mood
___ ___ Loss of interest or pleasure in things I'm normally interested in
___ ___ Difficulty falling asleep
___ ___ Difficulty staying asleep or waking up too early
(Average number of hours you are sleeping per night? _____)
___ ___ Sleeping too much
___ ___ Increased appetite/weight gain (lbs._____)
___ ___ Decreased appetite/weight loss (lbs. _____)
___ ___ Fatigue/Poor energy level
___ ___ Decreased activity (work, social, physical, sexual)
___ ___ Poor concentration or slowed thinking
___ ___ Thoughts of suicide
___ ___ Excessive feelings of guilt or worthlessness
___ ___ Decreased sex drive or interest

3. Any of the following symptoms, more days than not, for months at a time:

___ ___ Excessive anxiety or worry for no good reason
___ ___ Trembling, twitching or feeling "shaky"
___ ___ Muscle tension or muscle aches
___ ___ Easily fatigued
___ ___ Dry mouth

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Recent Past

___ ___ Dizziness or lightheadedness
___ ___ Nausea, diarrhea or other stomach problems
___ ___ Frequent urination
___ ___ Feeling keyed up or on edge
___ ___ Irritability
___ ___ Trouble falling or staying asleep

4. Panic attacks (any period of extreme, increased anxiety lasting from a few minutes up to several hours) with any of the following symptoms:

___ ___ Panic attacks/anxiety attacks
___ ___ Persistent worry that I will have a panic attack
___ ___ Heart pounding or racing heart
___ ___ Trembling or shaking
___ ___ Sweating
___ ___ Choking
___ ___ Nausea or stomach problems
___ ___ Feelings of unreality
___ ___ Numbness or tingling sensations
___ ___ Feeling of smothering or shortness of breathe
___ ___ Fear of dying
___ ___ Fear of going crazy or doing something uncontrolled
___ ___ Chest pain or discomfort
___ ___ Dizziness, unsteady feelings or faintness
___ ___ Flushes, hot flashes or chills
___ ___ Avoiding situations or places that may cause panic or severe anxiety

5. Any of the following symptoms for <u>most of the day, nearly every day, for more than four days at a time:</u>

___ ___ Euphoric or "high" mood
___ ___ Irritable mood
___ ___ Decreased need for sleep without feeling tired
___ ___ Increased energy level
___ ___ Increased activity (work, social, physical, sexual)
___ ___ Thoughts speeded up or racing thoughts
___ ___ Increased talkativeness or being much more socially outgoing
___ ___ Making decisions too impulsively
___ ___ Going on spending sprees

6. Check any of the following relating to your alcohol or drug use:

___ ___ I've felt alcohol or drugs were causing a problem for me

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Recent	Past	
___	___	I have felt guilty about my use
___	___	Others have annoyed me about my use
___	___	I have had a desire (or made unsuccessful efforts) to cut down or control my use
___	___	I've tried unsuccessfully to control my use
___	___	I've used alcohol or drugs more often or in larger amounts than I intended
___	___	I've had to increase my use of alcohol or drugs to get the desired effect
___	___	I've had problems with withdrawal (shakes, nervousness, insomnia, etc.) when
___	___	I've cut down or stopped using alcohol or drugs
___	___	I've been to a meeting of Alcoholics Anonymous or Narcotics Anonymous

7. Any of the following disturbances in eating or maintaining normal weight:

___	___	Insistence on maintaining body weight below expected for age and height
___	___	Intense fear of gaining weight or becoming fat even though underweight
___	___	I feel "fat" even when others see me as underweight
___	___	Eating binges
___	___	Feeling of lack of control of eating during eating binges
___	___	Vomiting or using laxatives to prevent weight gain
___	___	Being over-concerned about body weight and shape

8. Check any of the following that apply:

___	___	I tend to do things on impulse which end up being damaging to me or others
___	___	I have mood swings (depression, irritability, anger) lasting up to several hours
___	___	I have tried to commit suicide
___	___	I have made cuts, burns or other injuries to myself without wanting to kill myself
___	___	My relationships always seem to work out wrong
___	___	My mood often shifts from being either overconfident to having low self esteem
___	___	I have a hard time sympathizing with other's pain
___	___	I often feel others do not understand me
___	___	I tend to get very hurt or angry when I am criticized or rejected by someone
___	___	I tend to need a lot of reassurance or approval from others
___	___	I am very concerned about my appearance
___	___	Others often expect too much of me

9. Any of the following at any time:

___	___	Hearing voices that sound real even though they are not actually there
___	___	Vivid voices in my head that do not seem like my ideas
___	___	Feeling that others might be putting thoughts in my head
___	___	Feeling others might be able to read my thoughts
___	___	Others feel I am too suspicious or paranoid

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Recent	Past	
___	___	Feeling others might be talking about me

10. Any of the following problems relating to a past severe trauma or stress:

___	___	I have had an experience that was so traumatic that nearly anyone would have been seriously stressed by it
___	___	History of relatives hurting me physically or touching me in sexual areas
___	___	History of unwanted sexual contact
___	___	I have memories or dreams of a stressful event that I have trouble putting out of my head
___	___	I sometimes have flashbacks of past events; or I act or feel as though I am re-living a stressful event from the past
___	___	I try to avoid situations or people that remind me of a stressful event in the past

11. Any of the following obsessions or compulsions:

___	___	Excessive doubting; or repeated, forced unreasonable thoughts, images, or sounds that I cannot get out of my mind
___	___	Urges to check things, wash things, or count repeatedly
___	___	Excessive concern about coming into contact with germs or dirt
___	___	Excessive concern with right/wrong or morality
___	___	Excessive need for things to be exact or symmetrical

Thank you!