ADULT QUESTIONNAIRE

Name:	Date of Birth:
Address:	
Preferred phone number to reach you:	Email:
Is it okay to leave a message? Yes No (Please check one)	

Reason(s) for seeking treatment at this time?

_____
_____
_____
_____
_____

Briefly describe the history and development of this issue from onset to present.

_____
_____
_____
_____
_____

What attempts have you made so far to remedy this issue?

_____
_____
_____

What goals do you hope to accomplish through therapy?

_____
_____
_____

Prior Psychiatric Medications? Yes No (If yes, please list type, dosage, and dates, if known)

_____
_____

Prior Psychotherapy? Yes No (If yes, please list provider(s) and dates, if known)

_____
_____

Prior Psychiatric Hospitalizations? Yes No (If yes, please list location(s) and dates)

_____

How much have the following problems bothered you in the past week? (Check one score for each item)	Not at all	A little bit	Somewhat	Very Much	Extremely
	0	**1**	**2**	**3**	**4**
Fear of embarrassment causes me to avoid doing things or speaking to people.					
I avoid activities in which I am the center of attention.					
Being embarrassed or looking stupid are my worst fears.					
It scares me when I feel shaky.					
It scares me when I feel faint.					
It scares me when my heart beats rapidly.					
It scares me when I become short of breath.					
I avoid (or feel distress in) situations for fear of getting trapped or that I may have panic and not get help.					
I have phobias (excessive or unreasonable fears of specific situations or objects). Describe specific phobia:					
In your life, have you ever had any experience that was so frightening, horrible, or upsetting that in the past month you had any of the following					
I have had nightmares about the event or thought about it when I did not want to.					
I tried hard not to think about it or went out of my way to avoid situations that reminded me of the event.					
I have been constantly on guard, watchful, or easily startled.					
I have felt numb or detached from others, activities, or my surroundings.					

Please rate how much you agree with each item.	Not at all	A little bit	Somewhat	Very Much	Extremely
	0	**1**	**2**	**3**	**4**
Rate any: I am bothered by ideas, images, or impulses that seem silly, weird, nasty, or horrible and I have trouble getting rid of them; or I fear doing something impulsively that might cause embarrassment or harm.					
I check things too much (e.g. locks, switches, the stove) or do calculations repeatedly.					
Rate any: I need to do things in a ritualized way or have things exactly symmetrical or repeat actions until it feels “just right”.					
I engage in behaviors that harm my body (e.g. cutting, hitting or scratching self).					
I have intense feelings of anger that I have difficulty controlling.					
I react impulsively in ways that are either self damaging or damaging of my relationships.					
I have headaches.					
I have stomach problems.					
I have muscle or joint pains.					
I have gone for days at a time with excessive energy, little or no sleep, and have not felt tired.					
I have had periods of euphoria or irritability, where my thoughts raced and I could not slow my thinking down.					
I have had trouble with grandiose plans, spending sprees, sexual acting out, or other impulsive behavior that seemed right at the time.					

Please rate how much you agree with each item.	Not at all	A little bit	Somewhat	Very Much	Extremely
	0	**1**	**2**	**3**	**4**
I have been impaired much of my life by difficulty in finishing projects I have started.					
I have been impaired much of my life by a lack of organization.					
I have been impaired much of my life by problems focusing on tasks.					
I have been impaired much of my life by poor time management.					
I engage in compulsive/binge eating (i.e. eating more than twice what others might eat in a single sitting).					
I use purging, laxatives, or extreme exercise to control my weight.					
I have a history of not eating with excessive weight loss.					
I believe that others can put thoughts into my head.					
I hear voices talking to me or calling my name when no one is around.					
Sometimes I receive messages from the TV or radio that are specifically directed at me.					
I have thoughts of suicide.					
I have a specific plan to commit suicide.					
I have a current intent to commit suicide.					
I have guns in my home. Yes No (Check One)					
Prior history of suicide attempts? Yes No (Check One)					
In your relationship has there been any hitting, insulting, threatening to hurt, or screaming?					
I do not feel safe in my home.					

Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
	0	**1**	**2**	**3**
Little interest or pleasure in doing things?				
Feeling down, depressed, or hopeless?				
Trouble falling asleep or staying asleep, or sleeping too much?				
Feeling tired or having little energy?				
Poor appetite or overeating?				
Feeling bad about yourself - or that you are a failure or have let yourself or your family down?				
Trouble concentrating on things, such as reading the newspaper or watching television?				
Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?				
Thoughts that you would be better off dead, or of hurting yourself in some way?				
Feeling nervous, anxious or on edge.				
Not being able to stop or control worrying.				
Worrying too much about different things.				
Trouble relaxing.				
Being so restless that it's hard to sit still.				
Becoming easily annoyed or irritable.				
Feeling afraid as if something awful might happen.				

Alcohol or Other Drug Use:		
In the last 12 months, have you abused alcohol or drugs?		
Do you have a drug or alcohol problem?	Yes	No
If you drink alcohol, please indicate current use (one drink equals 1 shot of liquor, 1 beer, or 1 glass of wine) 4 or more drinks per day, 3-1 drinks per day, 1 drink per day, less than 5/week		
Last drink (time and amount):		
Do you use drugs (including marijuana)?		
If yes, what drugs?		
How much?	How often?	
Have you ever tried cutting down on your drinking/drug use?	Yes	No
Have you ever felt angry/annoyed when asked about your drinking/drug use?	Yes	No
Have you ever felt guilty about your drinking/drug use?	Yes	No
Have you ever been arrested for a DUI?	Yes	No

Occupation:	Employer:
How long have you lived in this area?	Last grade of school completed?
Are you: Married Partnered Single Divorced Widowed	
Ethnicity?	Religion?

Family Data

Name	Check if living with you	Age, if living	Occupation	History of Mental Illness (if any) Please describe
Spouse/Partner				
	☐			
Children				
	☐			
	☐			
	☐			
	☐			
Any other family members with mental health issues				
	☐			
	☐			
	☐			