

**HRC BEHAVIORAL HEALTH & PSYCHIATRY, PA**  
**Confidential Adult Questionnaire**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please complete this form to help your clinician as he/she talks with you regarding your problems. If you are unsure about the answers to any of these questions, please discuss them with your clinician.

**Medical/Lifestyle History**

Current health       Poor                       Fair                       Good                       Excellent

Medication(s) currently used:

Medication/Dose	Date Prescribed	Why Prescribed	Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Reproductive History: (Female Only)

Number of Pregnancies: \_\_\_\_\_

Number of live births: \_\_\_\_\_

Currently pregnant:  Yes       No       Maybe

**Past Hospitalizations (Psychiatric/Chemical Dependency)**

Date(s)	Reasons	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Alcohol use**

How often do you use alcohol?     None       Monthly       Weekly       Daily

On the days that you drink, how many drinks do you usually have?

Less than 2               2-5               5 or more

Do you consider it a problem?     No     Yes; Do others consider it a problem?     No     Yes

Do you have problems at work/school because of drinking or drug use?     No     Yes

Have you had problems with alcohol in the past?     No     Yes

**Nicotine use**

Do you smoke or use tobacco now?                       No     Yes

How much? \_\_\_\_\_ How long? \_\_\_\_\_

Have you smoked or used tobacco in the past?     No     Yes

How much? \_\_\_\_\_ How long? \_\_\_\_\_

**Caffeine**

How many cups of caffeinated coffee/tea do you drink a day? \_\_\_\_\_

How many caffeinated soft drinks? \_\_\_\_\_ How much chocolate, cocoa? \_\_\_\_\_

**Drug use**

Marijuana:     None               Occasionally               Daily               Weekly

Do you use other non-prescription substances?    If yes, what substance? \_\_\_\_\_

How often?     Occasionally               Daily               Weekly

**Mental Health**

**Is there a family history of (check all that apply):**

- Alcoholism       Substance Abuse       Mental Illness       Suicide

If yes, please describe the relationship to you and the problem:

- 
- Have you attempted suicide?       No       Yes  
Do you currently have suicidal thoughts?       No       Yes  
Do you every feel angry enough at home, work, school to do something you might regret?  
 No       Yes

**Childhood History**

As a child did you have any problems with:

- |   |                             |                              |                   |
|---|-----------------------------|------------------------------|-------------------|
| <input type="checkbox"/> Learning disabilities    | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <b><u>Age</u></b> |
| <input type="checkbox"/> Hyperactivity            | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____             |
| <input type="checkbox"/> Bed wetting              | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____             |
| <input type="checkbox"/> School fears             | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____             |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____             |
| <input type="checkbox"/> Sexual or physical abuse | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____             |

Did you have any other major childhood (0-17 years) school, learning, or emotional problems?

- No    Yes   If so, please describe: \_\_\_\_\_
- 

**Family History**

Which of the following best describes the family in which you grew up ?

- |                    |   |         |   |   |   |   |                               |   |
|--------------------|---|---------|---|---|---|---|-------------------------------|---|
| Warm and Accepting |   | Average |   |   |   |   | Distant, Hostile and Fighting |   |
| 1                  | 2 | 3       | 4 | 5 | 6 | 7 | 8                             | 9 |

Was the family/home disrupted by serious illness/accident/death.separation/divorce?

- No    Yes   If yes, please describe \_\_\_\_\_
- 

**Legal History:**

- None    Litigation    Arrest    Victimization, specify \_\_\_\_\_

**Job Satisfaction:**

- Very Satisfied    Fairly Satisfied    Not At All Satisfied

Have you ever taken work leave for mental health/chemical dependency problems?

- No    Yes   How Long? \_\_\_\_\_

**Previous Counseling, EAP, or Chemical Dependency Services:**

Have you ever seen anyone or are you currently seeing anyone for:

- |                     |                             |                              |                         |                             |                               |
|---------------------|-----------------------------|------------------------------|-------------------------|-----------------------------|-------------------------------|
| Individual Therapy  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Marital/Couples Therapy | <input type="checkbox"/> No | <input type="checkbox"/> Yes  |
| Group Psychotherapy | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Sex Therapy             | <input type="checkbox"/> No | <input type="checkbox"/> Yes. |

If Yes, please list:

Facility/Counselor Name	Dates Seen	Reason Seen	Helpful?
_____	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes
_____	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes
_____	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes

Name \_\_\_\_\_

Date \_\_\_\_\_

### SYMPTOM CHECKLIST

Please check all of the following problems/symptoms which apply to you.

- |  |  |
|--|--|
| <input type="checkbox"/> Panicky feelings                    | <input type="checkbox"/> No sense of purpose                   |
| <input type="checkbox"/> Nervousness                         | <input type="checkbox"/> Shyness                               |
| <input type="checkbox"/> Anxiety                             | <input type="checkbox"/> Loneliness                            |
| <input type="checkbox"/> Fears                               | <input type="checkbox"/> Relationship problems                 |
| <input type="checkbox"/> Phobic Avoidance                    | <input type="checkbox"/> Job problems                          |
| <input type="checkbox"/> Procrastination                     | <input type="checkbox"/> Educational problems                  |
| <input type="checkbox"/> Nervous tics                        | <input type="checkbox"/> Financial problems                    |
| <input type="checkbox"/> Driven to perform certain behaviors | <input type="checkbox"/> Career issues                         |
| <input type="checkbox"/> Headaches                           | <input type="checkbox"/> Boredom                               |
| <input type="checkbox"/> Chest pains                         | <input type="checkbox"/> Temper outbursts                      |
| <input type="checkbox"/> Rapid heartbeat                     | <input type="checkbox"/> Anger problems                        |
| <input type="checkbox"/> Dizziness                           | <input type="checkbox"/> Loss of control                       |
| <input type="checkbox"/> Excessive sweating                  | <input type="checkbox"/> Suspicious of others                  |
| <input type="checkbox"/> Appetite problem                    | <input type="checkbox"/> Hearing unidentified voices or sounds |
| <input type="checkbox"/> Weight loss/gain                    | <input type="checkbox"/> Guilt                                 |
| <input type="checkbox"/> bowel/stomach trouble               | <input type="checkbox"/> Jealousy                              |
| <input type="checkbox"/> Bingeing                            | <input type="checkbox"/> Difficulty making decisions           |
| <input type="checkbox"/> Vomiting                            | <input type="checkbox"/> Homicidal thoughts                    |
| <input type="checkbox"/> Purging                             | <input type="checkbox"/> Suicidal thoughts                     |
| <input type="checkbox"/> Muscle tension                      | <input type="checkbox"/> History of abuse                      |
| <input type="checkbox"/> Pain                                | <input type="checkbox"/> Flash backs                           |
| <input type="checkbox"/> Hearing problems                    | <input type="checkbox"/> Time loss                             |
| <input type="checkbox"/> Menstrual Problems                  | <input type="checkbox"/> Feeling out of body                   |
| <input type="checkbox"/> Sexual problems                     | <input type="checkbox"/> Feeling unreal                        |
| <input type="checkbox"/> Drug/alcohol abuse                  | <input type="checkbox"/> Smelling unidentified odors           |
| <input type="checkbox"/> Depression                          | <input type="checkbox"/> Sensitivity to noise or lights        |
| <input type="checkbox"/> Unhappiness                         | <input type="checkbox"/> Racing thoughts                       |
| <input type="checkbox"/> Seasonal variations in mood         | <input type="checkbox"/> Withdrawal                            |
| <input type="checkbox"/> Tearfulness                         | <input type="checkbox"/> Reduced Concentration                 |
| <input type="checkbox"/> Loss of interest                    | <input type="checkbox"/> Memory Problems                       |
| <input type="checkbox"/> Sleep Problems                      | <input type="checkbox"/> Low self-esteem                       |
| <input type="checkbox"/> Nightmares                          | <input type="checkbox"/> Fatigue                               |