Adult Questionnaire for Dr. Kamdar

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.

Current Living Situation

Marital/Relationship Status:

☐ Single
☐ Married/Permanent Partner (how long? _____)
☐ Living with a Partner (how long? _____)
☐ Widowed (how long? _____)
☐ Separated (how long? _____)
☐ Divorced (how long? _____)
☐ Previous marriages/partnerships?
1 2 3 4 5 (how many? _____)

Names of Persons Living in Household	*Age*	*Relationship to Patient*	*Gender*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical/Lifestyle History

Name of Primary Care Physician _____
Address_____
City_____ State _____ Zip_____
Telephone_____
Most Recent Medical Examination: Month _____ Year_____

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
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

Name Relationship Problem

_____

_____

Childhood history

As a child did you have any problems with:

			Age
☐Learning disabilities	☐ No	☐ Yes	_____
☐Hyperactivity	☐ No	☐ Yes	_____
☐Bed wetting	☐ No	☐ Yes	_____
☐School fears	☐ No	☐ Yes	_____
☐Depression	☐ No	☐ Yes	_____
☐Sexual or physical abuse	☐ No	☐ Yes	_____

Did you have any other major childhood (0-17 years) school, learning, or emotional problems?
☐ No ☐ Yes If so, please describe: _____

_____

Have you ever taken work leave for mental health/chemical dependency problems? ☐ No ☐ Yes
If yes, how long? _____

Suicide

Have you attempted suicide? ☐ No ☐ Yes
Do you currently have suicidal thoughts? ☐ No ☐ Yes

Previous Counseling, EAP, or Chemical Dependency Services:

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

Individual Therapy ☐ No ☐ Yes Marital/Couples Therapy ☐ No ☐ Yes
Group Psychotherapy ☐ No ☐ Yes Sex Therapy ☐ No ☐ Yes.

If Yes, please list:

Facility/Counselor Name	Dates Seen	Reason Seen	Helpful?
_____	_____	_____	☐ No ☐ Yes
_____	_____	_____	☐ No ☐ Yes
_____	_____	_____	☐ No ☐ Yes

Name_____ Date _____

SYMPTOM CHECKLIST

Please check any of the following items which apply to your present condition. I know the list is long, but please read it carefully. Indicate by using the appropriate number. Use the number "1" if you are experiencing mild difficulty with an item or "2" if you are experiencing moderate to severe difficulty with an item listed below. Leave an item blank if you are experiencing no difficulty.

[ ] Headaches
[ ] Seasonal variations in mood
[ ] Dizziness
[ ] Fainting
[ ] Rapid heartbeat
[ ] Frequent indigestion
[ ] Loss of appetite
[ ] Rapid weight loss or gain
[ ] Increased appetite
[ ] Frequently crying or near crying
[ ] Frequently irritable
[ ] Loss of interest socially
[ ] Worrying much of the time
[ ] Unable to enjoy life
[ ] Dislike for weekends or holidays
[ ] Uncomfortably shy around others
[ ] Uncomfortable in crowds
[ ] Difficulty making friends
[ ] Unable to relax
[ ] Loss of interest in sex
[ ] Other sexual concerns
[ ] Problems with decision making
[ ] Difficulty concentrating
[ ] Sometimes panicky
[ ] Increasingly anxious
[ ] Specific fears (specify)
[ ] Seeing things that aren't there
[ ] Cold sensitivity
[ ] Other (specify)

[ ] Smell odors which are not present
[ ] Déjà vu
[ ] Loss of time
[ ] Unpleasant dreams
[ ] Sensitivity to bright lights
[ ] Sensitivity to noise
[ ] Premenstrual problems
[ ] Irregular menstrual cycle
[ ] Frequently sad
[ ] Overweight
[ ] Diarrhea
[ ] Constipation
[ ] Toothaches
[ ] Teeth grinding
[ ] Jaw pain
[ ] Jaw clenching
[ ] Problems with alcohol
[ ] Problems with drugs
[ ] Tired most of the time
[ ] Sleeping more than usual
[ ] Unable to get to sleep
[ ] Restless sleep or waking up early
[ ] Waking up frequently
[ ] Waking up without feeling rested
[ ] Suicidal thoughts
[ ] Recurring thoughts
[ ] Homicidal thoughts
[ ] Hair loss, hair changes
[ ] Dry skin, oily skin