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:			**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: _____

_____

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 ☐ 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