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

Name_____ Date _____

SYMPTOM CHECKLIST

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

[ ] Panicky feelings
[ ] Nervousness
[ ] Anxiety
[ ] Fears
[ ] Phobic Avoidance
[ ] Procrastination
[ ] Nervous tics
[ ] Driven to perform certain behaviors
[ ] Headaches
[ ] Chest pains
[ ] Rapid heartbeat
[ ] Dizziness
[ ] Excessive sweating
[ ] Appetite problem
[ ] Weight loss/gain
[ ] bowel/stomach trouble
[ ] Bingeing
[ ] Vomiting
[ ] Purging
[ ] Muscle tension
[ ] Pain
[ ] Hearing problems
[ ] Menstrual Problems
[ ] Sexual problems
[ ] Drug/alcohol abuse
[ ] Depression
[ ] Unhappiness
[ ] Seasonal variations in mood
[ ] Tearfulness
[ ] Loss of interest
[ ] Sleep Problems
[ ] Nightmares

[ ] No sense of purpose
[ ] Shyness
[ ] Loneliness
[ ] Relationship problems
[ ] Job problems
[ ] Educational problems
[ ] Financial problems
[ ] Career issues
[ ] Boredom
[ ] Temper outbursts
[ ] Anger problems
[ ] Loss of control
[ ] Suspicious of others
[ ] Hearing unidentified voices or sounds
[ ] Guilt
[ ] Jealousy
[ ] Difficulty making decisions
[ ] Homicidal thoughts
[ ] Suicidal thoughts
[ ] History of abuse
[ ] Flash backs
[ ] Time loss
[ ] Feeling out of body
[ ] Feeling unreal
[ ] Smelling unidentified odors
[ ] Sensitivity to noise or lights
[ ] Racing thoughts
[ ] Withdrawal
[ ] Reduced Concentration
[ ] Memory Problems
[ ] Low self-esteem
[ ] Fatigue