**DONNA BARTLETT, LCSW, LCAS, CMHt**

**Confidential Adult Questionnaire**

Patient Name:_____ Date: _____

Please complete this form and bring it with you to your appointment. It will help your therapist as you discuss your problems. If you are not sure about any of the questions, please be sure to bring them up during your appointment.

Reason for today's visit? _____

Have you ever seen anyone or are you currently seeing anyone for any of the following?

Please list dates for any that apply.

Individual Therapy_____ Group Therapy _____

Couples/Marital Therapy_____ Addictions Counseling_____

Hypnotherapy_____

Is/was your experience helpful or not? (please describe)_____

**Lifestyle History**

With whom do you currently live (people/pets)? _____

Are you happy with this arrangement? If not, why? _____

Are you now or have you ever been in the military or lived with someone who is/was? If so, with whom/where/combat experience?_____

**Medical History**

Current Health ____Poor ____Fair ____Good ____Excellent

When was your last physical exam? _____ When was your last dental exam?_____

Medication(s) you are currently using: if you need more space, please list on the back of this page.

| Medication/Dose | Date Prescribed | Why Prescribed | Prescribing Physician |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

List medications you have used in the past: _____

Reproductive History: (Female Only)

Number of Pregnancies: _____

Number of Live Births: _____

Currently pregnant: ____ Yes ____ No ____ Maybe

Have you ever had a seizure of any kind? If so, when/what type? _____

Have you ever had a head injury? If yes, when/how did it occur?_____

**Past Hospitalizations** (Mental Health/Chemical Dependency/Medical) If more, please write on back of this form.

| Date(s) | Reasons | Hospital/City/State |
|---|---|---|
| | | |
| | | |
| | | |

**Mental Health**

Is there a family history of any of the following problems (please circle all that apply and describe the person's relationship to you and the impact of the problem on you):

Mental health Suicide Alcoholism Substance Abuse Legal Gambling

_____

Have you attempted suicide?_____

Do you currently have suicidal thoughts?_____

Do you feel angry enough at home/work/school to do something that you might regret? _____

**Alcohol use**

How often do you use alcohol? ____None ____Monthly ____Weekly ____Daily

On the days that you drink, how many regular-size 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/home because of drinking? ____No ____Yes

Have you had any problems with alcohol use in the past? ____No ____Yes

**Drug Use**

Are you now or have you used illegal/street drugs or used prescribed medicine/drugs inappropriately? If so, what, how, and when?_____

Do you have problems at work/school/home because of drug use? ____No ____Yes

Have you had any problems with drugs in the past? ____No ____Yes

**Nicotine Use**

Current use - What type/how much/how often?_____

Past use – When/what type/how much/how often?_____

**Caffeine Use**

How many cups of coffee/tea, how many caffeinated sodas or energy drinks, how much chocolate/cocoa do you consume each day? _____

**Childhood History (age 0 – 17 years old)**

As a child did you have any problems with any of the following? (please circle any that apply and write your age when it occurred)

Learning disabilities_____ Hyperactivity_____

Bed wetting_____ Being bullied/bullying others_____

Depression_____ Sexual or physical abuse_____

Frequent moves_____ Parent's absence_____

Did you experience/witness/participate in any violence in your home/neighborhood?_____

Did you experience any other stressors which may have made you sad, mad, or fearful?_____

**Family History**

Which of the following best describes the family in which you grew up? (please circle any which apply and describe )

Warm and accepting Average Cold/distant Neglectful Chaotic Hostile/fighting Abusive

_____

Was the family/home disrupted by serious illness/accident/deployment/death/separation/divorce/incarceration?_____

_____

Did anyone in your family suffer from any medical/mental health/substance abuse/other unhealthy behavior: If so, who?_____

Who raised you?_____

**Legal History** Please check and describe if any apply:

____None ____Arrested ____Charged/Convicted ____Probation/parole ____Victimization

---

_____

**Employment History**

If you are currently employed, where/how long/job description? _____

What other types of work have you done in the past, if any_____

Do you like your work?____ Yes ____No. If not, what would you rather be doing?_____

Have you ever taken work leave for mental health or addiction problems? If yes, when/how long/what type?_____

_____

**Spiritual History**

Were you raised in any particular spiritual tradition/church?_____

What is your current spiritual status?_____

Name _____ Date _____

**SYMPTOM CHECKLIST**

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

____ Panicky feelings
____ Nervousness
____ Anxiety
____ Fears
____ 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 pro0blems
____ 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
____ 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
____ Social isolation
____ Reduced concentration
____ Memory problems
____ Low self-esteem
____ Fatigue