Nicole V Zellner, LLC 827 North Cass Street, Milwaukee, WI 53202

Adult Health and Psychosocial History Questionnaire

Name_____ Today's Date _____

Date of Birth_____ Age_____

Reason for seeking treatment:_____

_____

Goals you'd like to achieve in treatment:_____

Past/Current Medical/Emotional Conditions (Please circle all that apply):

Abnormal Blood Pressure
Addictions/Using
- Food
- Caffeine
- Drugs
- Alcohol
- Sex
- Spending
- Medication misuse
- Nicotine
- Other: _____

Allergies
Anemia
Anger Issues
Anxiety
Appetite Disturbance
Arthritis
Asthma
Aches/Pain
Cancer
Compulsions
Concentration Difficulties
Crying Spells
Depression
Diabetes
Diarrhea/Constipation
Dizziness
Eating Disorder
Epilepsy/Seizure Disorder
Emphysema
Fainting Spells
Fatigue
Fibromyalgia
Hallucinations
Headaches
Head Injury
Hearing Problems
Heart Problems
Hopelessness
Hormone Imbalances
HIV/AIDS/ARC+
Indigestion
Irritable Bowel Syndrome
Irritability
Kidney/Bladder Problems
Liver Disease
Memory Loss
Migraines
Nausea/Vomiting
Mood Swings
Neurological Disorders
Obsessions
Panic Attacks
Phobias/Fears
Sexual Issues
Sleep Problems
Social Withdrawal
Stroke
Thyroid Problems
Ulcers/ Abdominal Pain
Venereal Disease
Vision Problems
Weight Loss/Gain
Other_____

Additional Comments on above checklist: _____

Primary Care Physician _____Phone ( ) _____

Address_____

Psychiatrist _____Phone ( ) _____

Address_____

May we contact your physician/psychiatrist about your care (circle)? YES NO

Medication	Dosage	Frequency	Prescribing Doctor	Side Effects

Do you have any problems with chronic pain? YES NO

If yes, please explain: _____

Yes	No	Previous Treatment	Facility	Dates
		Have you ever received outpatient treatment for Mental Health issues?		
		Have you ever received inpatient or partial hospitalization for Mental Health issues?		
		Have you ever received outpatient treatment for Alcohol/Drug problems?		
		Have you ever received inpatient or partial hospitalization for alcohol or drug problems?		

Current Social, Family and Environmental Stressors (Please circle):

Abuse: Emotional, Physical, Sexual	Employment Change/Difficulties	Miscarriage
Birth, Adoption, Foster child	Family Relation Conflicts	School Difficulties
Career Transition	Financial/Legal	Separation
Death of a loved one	Illness	Trauma
Drug/Alcohol Abuse	Marriage/Marital Difficulties	Other:_____

Relationships

Are you currently in a relationship with a significant other? YES NO I'd rather not answer

Do you have any children currently living with you? YES NO

Who currently lives in your household at this time? (names/ages/relationship) _____

_____

_____

Employment/Education

Occupation_____ Employer/School:_____

Social and Leisure Activities

Identify exercise, interests, leisure/recreational activities that you participate in: _____

_____

_____

Spirituality

Do you have a religious preference? YES NO

Is your spiritual belief system part of your support system? YES NO

Do you have any spiritual concerns you would like to address in therapy? YES NO

If yes, please explain: _____

Cultural

Are there any cultural expectations, values or pressures causing conflicts in your life? YES NO

If yes, please explain: _____

Client Signature_____ Date_____