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Adult Health and Psychosocial History Questionnaire (Client Form)

Client Name:_____ Date of Birth_____ Today's Date _____

Reason Seeking Treatment:_____

_____

Goals you'd like to achieve in treatment:_____

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

__ Abnormal Blood Pressure
__ Accidents
__ 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 about your care? [ ] yes [ ] no [ ] Don't have a primary physician

Current Medication	Dosage	Frequency	Prescribing Doctor	Any Side Effects

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?		

Yes	No	Previous Treatment	Facility	Dates
		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 check):

__ Abuse: Emotional, Physical, Sexual
__ Accidents
__ Birth, Adoption, Foster child
__ Death of _____
__ Divorce/Separation
__ Drug/Alcohol Abuse
__ Employment Change/Difficulties
__ Family Relation Conflicts
__ Financial/Legal
__ Illness
__ Marriage (Recent)
__ Marital Difficulties
__ Miscarriage
__ Residential Move
__ School Difficulties
__ Separation/Abandonment
__ Other: _____
_____
_____

Please check the column that best describes how you feel you are doing in each life area.

LIFE AREA	1. No Problems	2. Mild	3. Moderate Problems	4. Significant	5. Serious Problems
Work/Job					
Marriage/Significant Other					
Parenting					
Social Life					
Financial					
Intimacy/Sexuality					
Family of Origin					
Legal					
School					
Other Relationships					
Physical Health					
Happiness/Well Being					

Social and Leisure Activities

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

Spirituality

Do you have a religious preference? [ ]Yes [ ]No Describe _____
_____

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

Cultural

What is your cultural heritage?_____
Are there any cultural expectations, values or pressures causing conflicts in your life? [ ] Yes [ ] No
If yes, please explain: _____
_____

Pain and Pain Management

Do you have any problems with chronic pain? [ ] Yes [ ] No Explain: _____
_____
_____
How do you manage pain? _____
_____
_____

Client Signature_____ Date _____