Adult Assessment Confidential Questionnaire

Client Name: _____ Date: _____

Please complete this form to help your therapist 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 therapist.

The Target Behaviors for Change (Presenting Problem): 1. _____

2. _____ 3. _____

Desired Outcome from Therapy: _____

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

Educational History

Your highest level of education or training completed:_____

Have you had any problems with attention, learning or behavior in school? ❑ No ❑ Yes

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 ever feel angry enough at home, work, or school to do something you might regret? ❑ No ❑ Yes

Childhood History
As a child did you have any problems with the following and if so, at what ages?
❑ 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			Somewhat Warm, Somewhat Cold or Fighting			Distant and Cold and/or Hostile and Fighting		
1	2	3	4	5	6	7	8	9

Was your family or home disrupted by serious physical, emotional or mental illness / accident / death / separation / divorce?
❑ No ❑ Yes If yes, please describe _____

_____

Who is currently living in your home? Any mental, emotional, physical health concerns?

_____

_____

Names and ages of your children: _____

Marriages/Divorces/Separations: _____
How long have you been in your current home? _____

Legal History: ❑ None ❑ Litigation ❑ Arrest ❑ Victimization, specify _____
Job Satisfaction: ❑ Very Satisfied ❑ Fairly Satisfied ❑ Not At All Satisfied
Have you ever taken work leave for health problems? ❑ No ❑ Yes How Long? _____

Previous Psychotherapy, EAP, or Chemical Dependency Services:
Have you ever seen anyone or are you currently seeing anyone for:
Individual Therapy ❑ No ❑ Yes DBT ❑ No ❑ Yes Marital/Couples Therapy ❑ No ❑ Yes
Group Psychotherapy ❑ No ❑ Yes DBT Skills Group ❑ No ❑ Yes Sex Therapy ❑ No ❑ Yes
If Yes, please list:

Facility/Therapist Name	Dates Seen	Reason Seen	Helpful?
_____	_____	_____	❑ No ❑ Yes
_____	_____	_____	❑ No ❑ Yes

Checklist of Symptoms and Concerns

First, please check the following problems/symptoms which may apply to you. Second, and only for those symptoms that apply to you, please rate the intensity during the past month on a scale of 1 – 10, with a 1 being "minimal occurrence" and a 10 being the "maximum intensity" you can imagine.

❑ __ Nervousness
❑ __ Panicky feelings
❑ __ Anxiety
❑ __ Fears
❑ __ Phobic Avoidance
❑ __ Procrastination
❑ __ Nervous tics
❑ __ Hearing unidentified voices or sounds
❑ __ Headaches
❑ __ Chest pains
❑ __ Rapid heartbeat
❑ __ Dizziness
❑ __ Excessive worry
❑ __ Appetite problem
❑ __ Weight loss/gain
❑ __ Bowel/stomach trouble
❑ __ Bingeing
❑ __ Vomiting
❑ __ Purging
❑ __ Physical Pain
❑ __ Remembering trauma or abuse
❑ __ Time loss
❑ __ Suspicious of others
❑ __ Blaming others

❑ __ Missing sense of purpose
❑ __ Shyness
❑ __ Loneliness
❑ __ Relationship problems
❑ __ Job problems
❑ __ Educational problems
❑ __ Financial problems
❑ __ Boredom
❑ __ Temper outbursts
❑ __ Anger problems
❑ __ Loss of control
❑ __ Hearing problems
❑ __ Career issues
❑ __ Guilt or shame
❑ __ Jealousy
❑ __ Difficulty making decisions
❑ __ Homicidal thoughts
❑ __ Suicidal thoughts
❑ __ Muscle tension
❑ __ Flash backs
❑ __ Feeling unreal
❑ __ Self harm Urges or Behaviors
❑ __ Self criticism

❑ __ Depression
❑ __ Sensitivity to noise or lights
❑ __ Unhappiness
❑ __ Racing thoughts
❑ __ Seasonal variations in mood
❑ __ Withdrawal
❑ __ Tearfulness
❑ __ Reduced Concentration
❑ __ Loss of interest or apathy
❑ __ Memory Problems
❑ __ Sleep Problems
❑ __ Low self confidence
❑ __ Nightmares
❑ __ Menstrual or hormonal problems
❑ __ Fatigue
❑ __ Smelling unidentified odors
❑ __ Drug/alcohol abuse
❑ __ Sexual problems
❑ __ Use of pornography (past/present)
❑ __ Problematic sexual behaviors
❑ __ Problematic use of Internet
❑ __ Feeling out of body
❑ __ Impulse spending
❑ __ Driven to perform certain behaviors

On a 1-10 scale, with 10 being "excellent/completely satisfactory" and 1 being "poor/completely unsatisfactory, please indicate your level of satisfaction, during the past month.

How are your relationships with all of whom you live at your home? __

How would you describe the relationships with your (other) family and friends? __

How would you describe your experience at work/school? __

How well are you making time for fun or relaxing activities? __

Making time for connecting with people in your community? __

How are you doing with exercise for your health? __ Eating well? __ Sleeping well? __

❑