CLIENT INFORMATION

Adult Version

Please print or write legibly.

Please complete this questionnaire as completely and accurately as you can.

Information you provide is confidential and will be used to help provide good service to you.

Some questions may seem irrelevant, but only by asking can we fully help detect or rule out problems.

Circle key words, write N/A for "not applicable," or write "SAME" if your answers repeat.

If you are unsure about how to answer an item, please consult the doctor.

Thank you for your cooperation.

Rev 5/23/01

CLIENT IDENTIFYING INFORMATION

Your full name: _____

Home address: _____

Home phone: (_____) _____ Work phone: (_____) _____

Occupation: _____ Employer: _____

Work address: _____

Social Security #: _____ Driver's license #/State: _____

Date of birth: _____ Age: _____ Gender: M F

Birth place: _____ Primary language, if other than English: _____

Race/ethnicity/nationality: _____ Religious affiliation: _____

Marital status: Never Married Married Separated Divorced Widowed Other

Living situation: Alone Spouse Significant Other Children Parent(s) Roommate(s)

Highest education completed: Grade School High School Vocational College Graduate School

Who referred you? _____

Person to contact in the event of an emergency:

Name: _____ Relationship: _____

Home phone: (_____) _____ Work phone: (_____) _____

If other than client, name of insured person/subscriber: _____

Name of your health insurance company: _____

Address of insurance company: _____

Phone: (_____) _____

Group name: _____ Member #: _____

CURRENT CONCERNS

Describe your reasons for seeking services at this time. Start with your most serious concern. Include the date that your concerns began and events which made these issues surface.

_____

_____

_____

_____

_____

_____

_____

What is the result you expect from seeking services at this time?

_____

_____

_____

_____

_____

_____

_____

Have you ever seen a counselor or psychotherapist before? Y N
Have you ever received a psychological evaluation or testing before? Y N
Have other family members been in therapy before? Y N

If yes to any of the above items, state when, by whom, for what purpose, and the outcome:

_____

_____

_____

_____

_____

_____

_____

CURRENT SYMPTOMS

Are you experiencing any of the following?

_____ Insomnia, difficulty falling asleep or staying asleep through the night
_____ Nightmares
_____ Overeating, not eating, or deliberately vomiting
_____ Nail-biting
_____ Over-anxious, nervous, tense, keyed-up
_____ Fears
_____ Panic attacks
_____ Vivid images, daydreams, or flashbacks of an event
_____ Feelings of detachment or unreality
_____ Phobias, avoiding certain things or situations
_____ Excessive rumination or worrying
_____ Easily distracted, trouble concentrating
_____ Easily startled, jumpy
_____ Restless, fidgety
_____ Unusually high energy
_____ Unusually upset, agitated
_____ Cry easily
_____ Irritable, touchy, moody
_____ Anger, hostility, flaring temper
_____ Shy
_____ Stuttering, stammering
_____ Overly compliant or passive
_____ Drinking too much alcohol
_____ Recreational drug use
_____ Sexual problems
_____ Depressed, sad, blue, downhearted
_____ Feel worthless or guilty
_____ Lack of friends
_____ Avoiding people
_____ Withdrawal from family
_____ Loneliness
_____ Lack of interest in usual interests, hobbies
_____ Tired, lethargic, listless, low energy, worn out
_____ Forgetful, trouble with memory or recall
_____ Become lost and don't know where I am
_____ Accident-prone
_____ Difficulty making decisions
_____ Problems thinking clearly
_____ Hearing voices or strange sounds
_____ Unreal or strange thoughts
_____ Belief that others want to hurt you
_____ Thoughts about death, wishing to die
_____ Suicidal intentions or plans
_____ Wanting or threatening to hurt others
_____ Fearful of losing control
_____ Other: _____

Describe any experiences of compulsive, repetitive, or habitual behaviors or thoughts that are of concern to you or to the people close to you. For example: gambling, spending money, sexual behavior, eating, exercise, television viewing, hoarding, checking, counting, washing, illness-related behavior, use of obscene language, or thoughts of harming someone.

_____

_____

_____

PERSONALITY

How would you describe yourself?

_____ Kind
_____ Aggressive
_____ Cooperative
_____ Competitive
_____ Outgoing
_____ Concerned
_____ Passive
_____ Stubborn
_____ Perfectionistic
_____ Persistent
_____ Sensitive
_____ Worrier
_____ Good sense of humor
_____ Serious
_____ No sense of humor
_____ Poor sport
_____ Generous
_____ Agitator
_____ Impulsive
_____ Selfish
_____ Sarcastic
_____ Indifferent
_____ Critical
_____ Responsible
_____ Confident
_____ Assertive
_____ Unreliable
_____ Obedient
_____ Happy
_____ Unhappy
_____ Optimistic
_____ Naive
_____ Pessimistic
_____ Bossy
_____ Dependable
_____ Shy
_____ Moody
_____ Responds with very high intensity
_____ Other personality traits (list below):

MEDICAL INFORMATION

Name of primary care physician: _____

Physician's address: _____

Physician's phone number: (_____) _____

When was your last physical examination performed: _____

Are you under the care of any other health professionals? If yes, specify:

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Are you currently being treated for any medical conditions? If yes, explain:

_____

_____

_____

Are you taking any prescription or non-prescription (over-the-counter) medications now? If yes, list drug name, dosage/frequency, purpose for which intended, and by whom prescribed:

Drug name	Dosage (Amount)	Frequency	Purpose	Doctor

_____

_____

_____

Prior medication history:

Prior history of hospitalizations or surgeries:

HEALTH HISTORY AND SYMPTOMS

Check all of the following which apply:

Past	Present		Past	Present	
_____	_____	Measles	_____	_____	Pain anywhere in your body
_____	_____	German measles	_____	_____	Frequent stomach aches, abdominal pains
_____	_____	Mumps	_____	_____	Vomiting
_____	_____	Roseola	_____	_____	Indigestion, gas, heartburn
_____	_____	Chicken pox	_____	_____	Diarrhea or constipation
_____	_____	Scarlet fever	_____	_____	Jittery, trembling, shaky
_____	_____	Rheumatic fever	_____	_____	Heart pounds, flutters, or beats rapidly
_____	_____	Whooping cough	_____	_____	Frequent sweating
_____	_____	Bronchitis	_____	_____	Short of breath, feel you are choking or smothering
_____	_____	Pneumonia	_____	_____	Chest pains or discomfort
_____	_____	Encephalitis	_____	_____	Nausea or abdominal distress
_____	_____	Meningitis	_____	_____	Dizziness, unsteady on your feet, fainting
_____	_____	Polio	_____	_____	Numbness or tingling sensations
_____	_____	Paralysis	_____	_____	Chills or hot flashes
_____	_____	Diabetes	_____	_____	Weight change: Gain or loss (circle).
_____	_____	Congestive heart failure			Number of pounds: _____ Over what period of time: _____
_____	_____	Chronic lung disease	_____	_____	Excessive thirst or dry mouth
_____	_____	Cancer	_____	_____	Skin problems
_____	_____	Migraines	_____	_____	Frequent colds. Number in the past year: _____
_____	_____	Thyroid problem	_____	_____	Coughing or wheezing
_____	_____	Epilepsy	_____	_____	Drug reactions
_____	_____	Chorea	_____	_____	Food hypersensitivity
_____	_____	Ulcers	_____	_____	Fevers over 104 degrees
_____	_____	Asthma	_____	_____	Serious accidents
_____	_____	Arthritis/rheumatism	_____	_____	Broken bones
_____	_____	Sciatica	_____	_____	Head injury
_____	_____	Hypertension or high blood pressure	_____	_____	Unconsciousness
			_____	_____	Frequent headaches
_____	_____	Angina	_____	_____	Double or blurry vision
_____	_____	Allergies to: _____	_____	_____	Staring attacks
_____	_____	Other medical conditions (specify):	_____	_____	Muscle jerks or tics
			_____	_____	Blank spells, lapses of consciousness
			_____	_____	Convulsions, seizures
			_____	_____	Smell any unusual odors
			_____	_____	Weakness or fatigue
			_____	_____	Joint pain
			_____	_____	Lumps anywhere in the body. Specify where: _____
			_____	_____	Physical disability
			_____	_____	Pregnancy
			_____	_____	Sexually transmitted disease
			_____	_____	Other physical problems (specify):

Do you have vision problems? Y N
Do you wear glasses or contact lenses? Y N
Are you color-blind? Y N
Do you have hearing problems? Y N
Do you wear a hearing aid? Y N

Do you use any prosthetic (artificial) devices? If yes, what? _____

HEALTH STATUS

Rate your current overall health now: Excellent Good Fair Poor

Compared to one year ago, how would you rate your overall health now?
_____ Much better now
_____ Somewhat better now
_____ About the same
_____ Somewhat worse now
_____ Much worse now

Identify any of the below activities that are now limited by your current health that you might otherwise do during a typical day:
_____ Vigorous exercise (strenuous sports, running, etc.)
_____ Moderate activity (vacuuming, moving a table, etc.)
_____ Lifting or carrying parcels, groceries
_____ Climbing flights of stairs
_____ Bending, kneeling, stooping
_____ Walking several blocks or more
_____ Bathing or dressing yourself

LIFESTYLE HABITS

How much caffeinated coffee/tea/soft drinks per day: _____

How much smoking/cigarettes/tobacco per day: _____

Type and frequency of exercise per week: _____

Type of hobbies, recreation, leisure interests: _____

Work schedule: _____

Average number of hours per week spent at work: _____

SUBSTANCE USE

Indicate your use of alcohol or recreational drugs:

Substance name	Amount/Frequency	Time Last Used

FAMILY HEALTH HISTORY

Check any of the following which apply to immediate and extended family members and identify to whom the item applies:

_____ Medical illness: _____
_____ Physical handicap: _____
_____ Diabetes
_____ Cancer
_____ Progressive neurological disease
_____ Migraine headaches
_____ Fainting attacks
_____ Black out spells
_____ Seizures
_____ Alcoholism
_____ Drug addiction
_____ Nervous breakdown
_____ Depression
_____ Mood swings
_____ Mental illness
_____ Learning problems
_____ Mental retardation
_____ Developmental delays
_____ Suicide or attempt
_____ Other: _____

FAMILY INFORMATION

If applicable, your spouse's/significant other's name: _____

Date of birth: _____ Age: _____ Gender: M F

Birth place: _____ Primary language, if other than English: _____

Race/ethnicity/nationality: _____ Religious affiliation: _____

Highest education completed: Grade School High School Vocational College Graduate School

Occupation: _____ Employer: _____

Rate this relationship now: Excellent Good Fair Poor

Each spouse's Name	Date of Marriage	Number of Separations	Date of Termination
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Your children's Name	Age	Gender	Living with whom?	Planned pregnancy?
_____	_____	_____	_____	Y N
_____	_____	_____	_____	Y N
_____	_____	_____	_____	Y N
_____	_____	_____	_____	Y N

Step-children's Name	Age	Gender	Living with whom?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you plan to have children/more children in the future? Y N

If all children are not living with you, reason they are living elsewhere:

_____

Is anyone in your family adopted? If so, who and at what age:

_____

Others living in your home: _____

Number of dependents: _____ Gross family/household income per month: _____

CHILDHOOD INFORMATION

When did you leave the home you grew up in? _____

Were you raised primarily by your (circle): Mother Father Other Primary Care Giver

MOTHER

Mother's age: _____ Race/ethnicity/nationality: _____ Religion: _____

Mother's educational history: _____

Mother's occupation: _____

Mother's work history: _____

Mother's health: in good health/difficulties _____

If deceased: How old were you when she died? _____ How old was she? _____

What were the causes of her death? _____

Were you living at home? Y N

Were you sad when she died? _____

FATHER

Father's age: _____ Race/ethnicity/nationality: _____ Religion: _____

Father's educational history: _____

Father's occupation: _____

Father's work history: _____

Father's health: in good health/difficulties _____

If deceased: How old were you when he died? _____ How old was he? _____

What were the causes of his death? _____

Were you living at home? Y N

Were you sad when he died? _____

OTHER PRIMARY CARE GIVER

Other Primary Care Giver's history: _____

_____

_____

Your brothers and sisters

Name	Age	Gender
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

While growing up, what was the quality of your relationships (close, distant, hostile, etc.):

Mother: _____

Father: _____

Other primary care givers: _____

Siblings: _____

Others living at home: _____

Friends: _____

Classmates: _____

Teachers: _____

EDUCATIONAL INFORMATION

What were your school years like?

Pre-school: _____

Kindergarten: _____

First grade: _____

Elementary school: _____

Junior high/middle school: _____

High school: _____

Vocational school: _____

College: _____

Other schooling: _____

Were you enrolled in _____ public school? or _____ private school?

How many moves/school changes? _____

Academic grades: _____

Athletic grades: _____

Citizenship grades: _____

Rate the following subjects you studied:

	Hard Subject	Easy Subject	Fun Subject
Reading	_____	_____	_____
Writing	_____	_____	_____
Math	_____	_____	_____
History	_____	_____	_____
Geography	_____	_____	_____
Civics/government	_____	_____	_____
Foreign language: _____	_____	_____	_____
Science	_____	_____	_____
Music	_____	_____	_____
Art	_____	_____	_____
Drama	_____	_____	_____
Home economics	_____	_____	_____
Industrial arts	_____	_____	_____
Athletics	_____	_____	_____
Other: _____	_____	_____	_____
Elective: _____	_____	_____	_____

Were you ever involved in any organized after school program? If so, what?

Identify any special school arrangements you received:

_____ Grades, classes, or subjects repeated or skipped
_____ Enrolled in gifted program
_____ Took advanced placement classes
_____ "Pull out" help
_____ Tutoring
_____ Speech, language, or vision therapy
_____ Adaptive physical education classes
_____ Ever suspended or expelled
_____ Attended continuation school
_____ Other special arrangements: _____

Describe any behavioral or learning problems at school:

_____

_____

_____

MILITARY SERVICE

If you have served in the military, identify what branch, whether drafted or volunteered, dates in the service, what rank and duties, whether you saw combat, and type of discharge:

_____

_____

_____

FOREIGN TRAVEL

Have you ever traveled out of the country or lived any part of your life out of the country? (For example, lived on an overseas military base, foreign service, travel abroad, foreign exchange student, or emigrated to America.) If so, where, when, and for how long?

_____

_____

_____

WORK HISTORY

List your history of work in chronological order, including any periods of unemployment:

Employer Job/Duties Dates of Employment Reason for Leaving

_____

_____

_____

_____

_____

_____

SOCIAL/ENVIRONMENTAL STRESSORS

Have you experienced any of the following?

Past year	Lifetime	
_____	_____	Outstanding personal achievement
_____	_____	Major change in work or school situation
_____	_____	Major change in economic situation
_____	_____	Major change in living situation or housing
_____	_____	Major change in social activities
_____	_____	Major change in marriage or primary relationship
_____	_____	Changes in the family group
_____	_____	Family conflict
_____	_____	Separation or divorce
_____	_____	Chronic or disabling illness of family member
_____	_____	Death of a close family member or loved one
_____	_____	Significant loss or rejection
_____	_____	Exposure to disaster, either natural or man-made
_____	_____	Exposure to toxic chemicals (lead, mercury, cadmium, paint, solvents, etc.)
_____	_____	Legal problems
_____	_____	Trouble with police or detention in jail
_____	_____	Homelessness
_____	_____	Residence in high-crime neighborhood
_____	_____	Witness to violence
_____	_____	Victim of physical or sexual assault or rape
_____	_____	Unwanted pregnancy
_____	_____	Refugee or exile
_____	_____	Other source(s) of stress: _____

SUPPORT SYSTEM

During times of stress, who in your life now is an important source of support to you personally--in terms of emotional support, moral support, financial support, etc.:

Primary relationship _____

Family members _____

Friends _____

Co-workers _____

Neighbors _____

Community groups _____

Others _____

LIFE FUNCTIONING

Rate in what areas your present difficulties hinder your life:

	None	Mild	Moderate	Severe
Job/school attendance	_____	_____	_____	_____
Job/school performance	_____	_____	_____	_____
Job/school relationships	_____	_____	_____	_____
Housework/work to maintain home	_____	_____	_____	_____
Child care	_____	_____	_____	_____
Marriage/intimate relationship	_____	_____	_____	_____
Friendships	_____	_____	_____	_____
Errands/routine activites	_____	_____	_____	_____
Personal dress/hygiene	_____	_____	_____	_____

"None" means functioning well or at least average.

"Mild" means noticeable interference, yet able to function.

"Moderate" means clear negative effects on life that get in the way.

"Severe" means obvious impairment with minimal or no ability to fulfill task.

Please use the space below for any additional comments you would like to offer about any information you have provided in this form.

If any facts about your life which you think are important have been overlooked, please state them below as well.

Thank you very much for your help and cooperation.