Adult Questionnaire

Name________________________________ Today's Date ____________________

Date of Birth________________ Age_______ Gender: M________ F__________

Presenting Concerns and Mental Health Services

What problems have you/your family had that led you to seek help?

What kind of service or help are you interested in?

How were you referred to this office?

Please list any mental health services you have received.

		Provider/ Agency	Dates of Service
	Psychological assessment		
	Individual or family counseling		
	Psychiatric medication		
	Chemical dependency treatment		
	Psychiatric hospitalizations		

Have you seen another psychologist or psychiatrist this year? __________ If yes, whom____

Are you currently taking any medication?
Name of medication: Dose/Frequency Prescribing MD

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What do you see as your strengths?

What do you see as your families' strengths?

Please check all items that apply to you and add any additional information.

	Problems with appetite or eating	
	Sleep Problems	
	Low energy or Fatigue	
	Few interests or activities	
	Sadness or depression	
	Irritable or easily upset	
	Problems with anger or aggression	
	Suicidal thoughts or actions	
	Self-destructive behavior	
	Repetitive habits or tics	
	Unusual thoughts	
	Socially isolated	
	Difficulty getting along with others	
	Low self-esteem	
	Problems with anxiety	
	Fears	
	Panic attacks	
	Unusual behaviors	
	Physical problems	
	Legal involvement	
	Chemical use	
	Physical or sexual abuse	

Is there anything else you want me to know?

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