Holland Hospital

BEHAVIORAL HEALTH SERVICES

Adult Confidential Questionnaire

Please take a few minutes to complete this questionnaire. This information will be helpful to us as we learn about your personal concerns. It is very important that you provide accurate information. This will become part of your confidential medical record.

***PLEASE COMPLETE ALL SECTIONS** (w/black or blue ink only)* Today's Date: ___/___/___

PATIENT INFORMATION

Name: _____ DOB: ___/___/___ Age: _____
Last First

Preferred Name: _____ Previous or Maiden Name: _____

Gender: ❒ M ❒ F ❒ Other: _____ Pronoun(s): _____

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed

Mailing Address _____ Street, Apt. #
_____ City, State, Zip

Current Residence _____ Street, Apt. #
_____ City, State, Zip

Home Phone: (___) _____ Daytime/Work: (___) _____ Cell: (___) _____

Preferred Method of Contact & Times: _____

Employment: ❒ Full Time ❒ Part Time ❒ Self-Employed ❒ Student
❒ Other: _____

Employer: _____

SPOUSE/SIGNIFICANT OTHER INFORMATION

Name: _____
Last First

_____
Street, Apt. # City, State Zip

EMERGENCY CONTACT

Name: _____ Relationship: _____
Last First

_____ (___) _____ (___) _____
Street, Apt. # Home Phone Cell Phone

_____ (___) _____
City, State, Zip Daytime/Work

Primary Care Physician: _____ Phone: (___) _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy Holder: _____
Group #: _____ DOB of Policy Holder: ___/___/___
Employer: _____ Contract #: _____

Secondary Insurance: _____ Policy Holder: _____
Group #: _____ DOB of Policy Holder: ___/___/___
Employer: _____ Contract #: _____

Adult Confidential Questionnaire

Initial Assessment (Part I)

Name: _____ DOB: ____/____/____ Age: _____
Last First

What symptoms or problems bring you to this appointment? _____

_____

_____

_____

_____

FAMILY INFORMATION

Who currently lives with you?

Name	Age	Relationship	Quality of Relationship

Do you have children living away from home?

Name	Age	Relationship	Quality of Relationship

Who do you have available for support?

Name	Age	Relationship

Marital Status

❒ Single
❒ Separated, length of time: _____
❒ Divorce in progress, length of time: _____
❒ Divorced, length of time: _____
❒ Unmarried, living together, length of time: _____
❒ Legally married, length of time: _____
❒ Widowed, length of time: _____
❒ Number of marriages: _____

Assessment of current relationship: ❒ Good ❒ Fair ❒ Poor

CHILDHOOD HISTORY

Number of siblings: _____ Sisters: _____ Stepsisters: _____ Brothers: _____ Stepbrothers: _____

Your position from top of sib-ship: _____

Lived with: ❒ Parents _____ ❒ Parents and siblings ❒ Other: _____

Parents are/were: ❒ Married ❒ Divorced ❒ Separated

Mother's age: _____ (If deceased, at what age ____. Your age at that time ____.) Stepmother: ❒ Yes ❒ No

Father's age: _____ (If deceased, at what age ____. Your age at that time ____.) Stepfather: ❒ Yes ❒ No

EDUCATION

Highest grade level obtained: _____

List any barriers to learning (i.e. learning disability, vision or hearing impairment) _____

I learn effectively through: ❒ Speakers ❒ Video ❒ Audio tapes ❒ Written material

EMPLOYMENT

❒ Employed, Position: _____ ❒ Retired ❒ Unemployed, explain: _____

Concerns/Work Stress: ❒ None ❒ Yes, explain: _____

SOCIAL RELATIONSHIPS

Usual response to social relationships:

❒ Avoidant ❒ Shy/Withdrawn ❒ Follower ❒ Friendly
❒ Leader ❒ Argumentative ❒ Aggressive ❒ Outgoing

Are you satisfied with current social relationships? ❒ Yes ❒ No, explain: _____

Recent changes in social relationships? ❒ No ❒ Yes, explain: _____

FINANCIAL CONCERNS: ❒ No ❒ Yes, explain: _____

TREATMENT HISTORY

Have you had outpatient counseling or therapy before? ❒ No ❒ Yes

When and with whom? _____

Was it helpful? ❒ No ❒ Yes, explain: _____

Have you ever been treated with psychiatric medication(s)? ❒ No ❒ Yes

When and with whom? _____

What medications? _____

Did you experience any side effects? _____

Have you ever been hospitalized for a psychiatric condition? ❒ No ❒ Yes

If yes, give admission(s) date, hospital, and reason for admission: _____

Have you ever made a suicide attempt? ❒ No ❒ Yes, explain: _____

Have you ever engaged in self-injury? ❒ No ❒ Yes, explain: _____

CURRENT SUBSTANCE USE (check all that apply)

	Last Use Date/Time	Frequency	Dose/Amount
❒ None	-----	-----	-----
❒ Caffeine			
❒ Nicotine			
❒ Alcohol			
❒ Marijuana			
❒ Cocaine			
❒ Stimulants			
❒ Sedatives			
❒ Pain pills			
❒ Inhalants			

Have you experienced any consequences of usage?

❒ Social _____ ❒ Occupational: _____

❒ Legal _____ ❒ Other: _____

Have you had treatment for a substance use problem? ❒ No ❒ Yes

If yes, list dates, place, and result: _____

FAMILY TREATMENT HISTORY

Is there any family history of mental health or psychiatric problems, alcoholism, or other substance abuse?

❒ No ❒ Yes If yes, please list below:

How is person related to you?	Type of Problem	Treatment/ Medications	Helpful?
			❒ Yes ❒ No
			❒ Yes ❒ No
			❒ Yes ❒ No
			❒ Yes ❒ No
			❒ Yes ❒ No

Is there any history of suicide in your family? ❒ No ❒ Yes **If so, what relation to you:**

DEVELOPMENT

History of abuse or trauma? ❒ No ❒ Yes If yes, type: ❒ Sexual ❒ Physical ❒ Emotional

Abuse was as: ❒ Victim ❒ Perpetrator Explain: _____

Problems transitioning from one life stage to another? ❒ No ❒ Yes

If yes, please explain: _____

CULTURAL/ETHNICITY

Are there any cultural or ethnic issues you would like us to be aware of? ❒ No ❒ Yes

If yes, explain: _____

SPIRITUAL/RELIGIOUS

Do you have a supportive faith community? ❒ No ❒ Yes

How important have spiritual matters been? ❒ Minimal ❒ Moderate ❒ High

Spiritual needs? ❒ No ❒ Yes Explain: _____

_____

LEISURE/RECREATIONAL

What hobbies or activities are you interested or involved in?

Activity	Recent Changes	If yes, explain:
_____	❒ No ❒ Yes	_____
_____	❒ No ❒ Yes	_____
_____	❒ No ❒ Yes	_____
_____	❒ No ❒ Yes	_____

MILITARY HISTORY

❒ No ❒ Yes If yes. Branch: _____

Type of Discharge: _____

Length of Service: _____

Comments (optional): _____

LEGAL

Present legal involvement: ❒ None ❒ On Probation ❒ On Parole

Probation/Parole Officer: ❒ No ❒ Yes Name: _____

Pending legal charges: ❒ No ❒ Yes Explain: _____

Past legal charges: ❒ No ❒ Yes Explain: _____

_____

ADDITIONAL COMMENTS (If needed):

Is there anything else about you that may be important for us to know so we may be of help to you?

PERSONAL CHECKLIST: Please rate any/all of the following that apply to you within the past **two weeks**

Rate for severity: 1 = Mild 2 = Moderate 3 = Severe

____ depressed
____ sad
____ crying spells
____ feeling hopeless
____ feeling helpless
____ feeling worthless
____ suicidal thoughts
____ lack of energy
____ hard to concentrate
____ daydream too often
____ trouble falling asleep
____ trouble staying asleep
____ problems with memory
____ can't make decisions
____ excessive appetite
____ lack of appetite
____ loss of weight
____ weight gain
____ not enjoying things
____ unable to have fun
____ grouchy
____ irritable
____ quick-tempered
____ feeling easily hurt
____ dislike vacations
____ dislike weekends
____ dread holidays
____ don't like being alone
____ impatient with people
____ overly sensitive
____ shyness
____ feeling inferior
____ critical of self
____ critical of others
____ lack self-confidence
____ hide behind a mask
____ "live" in the past
____ bored often
____ lonely
____ empty

____ loss of sexual interest
____ sexual problems
____ feel like smashing things
____ feel like hurting someone
____ fight / quarreling
____ overly ambitious
____ too much energy
____ naturally "wired"
____ mood swings
____ racing thoughts
____ invincible
____ creative
____ can't sit still
____ driven
____ little need for sleep
____ jittery
____ fidgety
____ unable to relax
____ anxious inside
____ nervous
____ feeling tense
____ always worried
____ frightening images
____ feeling panicky
____ fearful
____ hands shaky
____ easily startled
____ vague disturbing memories
____ nightmares
____ fainting spells
____ fast heartbeat
____ sweaty hands
____ frequent sweating
____ short of breath
____ muscles tight
____ muscles ache
____ muscles "jumping"
____ light headed
____ dizzy spells
____ headaches

____ constipation
____ stomach troubles
____ "butterflies" in stomach
____ vomiting
____ diarrhea
____ picking at skin/hair
____ hands and feet cold
____ can't be in crowds
____ don't want to be embarrassed
____ counting things over & over
____ checking things over & over
____ repetitive thoughts
____ perfectionistic
____ must do certain acts
____ problems at work
____ problems w/spouse (partner)
____ problems w/parents
____ problems w/children
____ problems w/family
____ financial problems
____ can't handle money
____ obsess about problems
____ can't hold a job
____ use of medication
____ drug use
____ excessive alcohol
____ blackouts
____ passing out
____ DWI(s)
____ lost job due to drinking/drugs
____ people have it in for me
____ always early for things
____ always late for things
____ worry about health
____ worried about aging
____ worried about death
____ poor health
____ no one understands me
____ can't make friends

H & P Medical Summary List

Do you have any current medical conditions? ❒ No ❒ Yes If yes, explain: _____

_____

CURRENT MEDICATIONS (Include non-prescription medications, vitamins, and herbal remedies.)

	Dose	Frequency	Reason	Who Prescribed?

Are you allergic to any medications? ❒ No ❒ Yes Which ones? _____

What kind of reactions do you have? _____

HEALTH FACTORS - Do you have any history of…?

❒ Blood Sugar Problems ❒ Heart Problems ❒ Prostrate Problems
❒ Cancer ❒ Kidney Problems ❒ Seizures
❒ Eye Disease ❒ Liver Problems ❒ Thyroid Disease
❒ Head Injuries ❒ PMS ❒ Other: _____

Describe: _____

_____

NUTRITION

Do you have a history of having unintentional weight gain or loss? ❒ Yes ❒ No
Do you have any concerns with your appetite or eating? ❒ Yes ❒ No If yes, explain: _____

_____

CHRONIC PAIN

Do you have a history of chronic pain? ❒ No ❒ Yes Describe: _____
Rate current level of pain – '1-10' ('1'-being the lowest, '10'-highest): _____
Current Treatment: _____

SURGICAL

Please list surgeries and dates: _____

_____

Date of last contact with Primary Care Physician: ___/___/___ Date of last physical: ___/___/___
Any problems found? _____
In the past year, have you received: ❒ Flu Shot (when) _____
❒ Pneumonia Vaccination (if over 65) (when) _____
Are your immunizations up to date? ❒ Yes ❒ No
If no, please contact your primary care physician for immunization update.

SEXUAL

Do you use birth control? ❒ Yes ❒ No ❒ N/A What kind? _____
Have you ever had a sexually transmitted disease? ❒ No ❒ Yes ❒ N/A
If yes, please explain: _____

FEMALES ONLY

Are your periods regular? ❒ Yes ❒ No ❒ N/A Date of last period? _____
Do you experience severe mood swings? ❒ Yes ❒ No ❒ N/A
Is there any possibility you may be pregnant? ❒ Yes ❒ No ❒ N/A