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: ______________________________ (Last, First) DOB: ___/___/___ Age: ______

Preferred Name: ______________________ Previous or Maiden Name: ______________________

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

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 ❒ Retired ❒ Disabled ❒ Other: ______________________

Employer: ______________________

SPOUSE/SIGNIFICANT OTHER INFORMATION

Name: ______________________________ (Last, First)

______________________ (Street, Apt. #) ______________________ (City, State) ______ (Zip)

EMERGENCY CONTACT

Name: ______________________________ (Last, First) Relationship: ______________________

______________________ (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 #: ______________________

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: _________

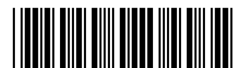
Your position from top of sib-ship: _________

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) ______________________

SOCIAL RELATIONSHIPS

Usual response to social relationships:

❒ Avoidant ❒ Shy/Withdrawn ❒ Follower ❒ Friendly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

Are you satisfied with current social relationships or have recent relationship changes? ❒ Yes ❒ No, 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? ______________________

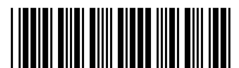
Did you experience any side effects? ______________________

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: ______________________

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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 trauma, abuse, or neglect? ❐ 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: ______________________

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RACE/GENDER IDENTITY

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

If yes, explain: ______________________

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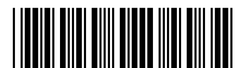

SPIRITUAL/RELIGIOUS

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

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

Spiritual needs? ❐ No ❐ Yes Explain: ______________________________

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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: ______________________________

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PPO / Restraining order: ❐ 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?

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Personal Treatment Goals:

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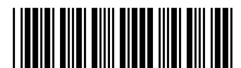

H & P Medical Summary List

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…?

❒ Autoimmune ❒ Cholesterol ❒ Kidney Problems ❒ Prostrate Problems
❒ Blood Sugar Problems ❒ Eye Disease ❒ Liver Problems ❒ Seizures
❒ Blood Pressure ❒ Head Injuries ❒ Neurological ❒ Thyroid Disease
❒ Cancer ❒ Heart Problems ❒ PMS ❒ Other: ______________________

Describe: ______________________

Receiving Treatment?: ______________________

NUTRITION

Do you have any concerns with your appetite or eating? ❒ Yes ❒ No If yes, explain: ______________________

Do you have a history of treatment for dietary patterns or concerns? ❒ Yes ❒ No

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? ______________________

Reproductive Health

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