

Adult Health and Psychosocial History Questionnaire (Client Form)

Client Name: _____ Date of Birth _____ Today's Date _____

Reason for Seeking Treatment: _____

Goals you'd like to achieve in treatment: _____

Past/Current Medical/Emotional Conditions (Please check all that apply):

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Abnormal Blood Pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Neurological Disorders |
| <input type="checkbox"/> Accidents | <input type="checkbox"/> Compulsions | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Obsessions |
| <input type="checkbox"/> Addictions/Using Food <input type="checkbox"/> Caffeine | <input type="checkbox"/> Concentration Difficulties | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Drugs <input type="checkbox"/> Alcohol | <input type="checkbox"/> Crying Spells | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Phobias/Fears |
| <input type="checkbox"/> Sex <input type="checkbox"/> Spending | <input type="checkbox"/> Depression | <input type="checkbox"/> Hormone Imbalances | <input type="checkbox"/> Sexual Issues |
| <input type="checkbox"/> Medication misuse | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS/ARC+ | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Nicotine | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Social Withdrawal |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies: _____ | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Irritability | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy/Seizure Disorder | <input type="checkbox"/> Kidney/Bladder Problems | <input type="checkbox"/> Ulcers/ Abdominal Pain |
| <input type="checkbox"/> Anger Issues | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Appetite Disturbance | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Migraines | <input type="checkbox"/> Weight Loss/Gain |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Mood Swings | |
| <input type="checkbox"/> Aches/Pain | <input type="checkbox"/> Headaches | | |

Additional Comments on above checklist: _____

Primary Care Physician _____ Phone () _____
Address _____

Psychiatrist _____ Phone () _____
Address _____

May we contact your physician about your care? [] yes [] no [] Don't have a primary physician

Current Medication	Dosage	Frequency	Prescribing Doctor	Any Side Effects

Yes	No	Previous Treatment	Facility	Dates
		Have you ever received outpatient treatment for Mental Health issues?		
		Have you ever received inpatient or partial hospitalization for Mental Health issues?		

Yes	No	Previous Treatment	Facility	Dates
		Have you ever received outpatient treatment for Alcohol/Drug problems?		
		Have you ever received inpatient or partial hospitalization for alcohol or drug problems.		

Current Social, Family and Environmental Stressors (Please check):

- | | | |
|---|---|---|
| <input type="checkbox"/> Abuse: Emotional, Physical, Sexual | <input type="checkbox"/> Employment Change/Difficulties | <input type="checkbox"/> Residential Move |
| <input type="checkbox"/> Accidents | <input type="checkbox"/> Family Relation Conflicts | <input type="checkbox"/> School Difficulties |
| <input type="checkbox"/> Birth, Adoption, Foster child | <input type="checkbox"/> Financial/Legal | <input type="checkbox"/> Separation/Abandonment |
| <input type="checkbox"/> Death of _____ | <input type="checkbox"/> Illness | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Divorce/Separation | <input type="checkbox"/> Marriage (Recent) | _____ |
| <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Marital Difficulties | _____ |
| | <input type="checkbox"/> Miscarriage | |

Please check the column that best describes how you feel you are doing in each life area.

LIFE AREA	1. No Problems	2. Mild	3. Moderate Problems	4. Significant	5. Serious Problems
Work/Job					
Marriage/Significant Other					
Parenting					
Social Life					
Financial					
Intimacy/Sexuality					
Family of Origin					
Legal					
School					
Other Relationships					
Physical Health					
Happiness/Well Being					

Social and Leisure Activities

Identify exercise, interests, leisure/recreational activities that you participate in: _____

Spirituality

Do you have a religious preference? [] Yes [] No Describe _____

Is your spiritual belief system part of your support system? [] Yes [] No

Do you have any spiritual concerns you would like to address in therapy? [] Yes [] No

Cultural

What is your cultural heritage? _____

Are there any cultural expectations, values or pressures causing conflicts in your life? [] Yes [] No

If yes, please explain: _____

Pain and Pain Management

Do you have any problems with chronic pain? [] Yes [] No Explain: _____

How do you manage pain? _____

Client Signature _____ Date _____