**ADULT PSYCHOTHERAPY QUESTIONNAIRE**

Date

**Your Name: Age: Height**: **Weight**:

***Area(s) you want to address in Psychotherapy (Circle as many as apply / Add any that are not listed):***

**Emotional Distress:** Depression Anxiety Irritability-Anger Fear Loneliness Loss/Grief

**Medical:** Specific Disease Chronic Pain Family Member ill Coping Skills

**Relationship Problems:** Dating Marital Family Workplace Community

**Behavior Problems:** Impulse Control Anger-Temper Cannot Relax Shyness

**Functional Limits:** Unable to Work Seeking Disability Benefits

**Other:**

***Personal & Family Background***

**Birthplace**: **Location(s) where you were raised**:

**Raised by (circle all that apply):**

Mother Father Stepmother

Stepfather Adoptive Mother Adoptive Father

Uncle

Aunt Grandparent(s) Foster Parent(s)

**Along with (circle all that apply):**

Only Child

Half Sister (s)

Adopted Sibling (s)

Full Sister (s) Full Brother(s)

Half Brother (s) Step Sister(s)

Step Brother (s)

**Religious Upbringing:** YES NO **Religion / Denomination:**

**Education (circle all that apply):** Public Schools Private Schools Military Academy Other

How many grades (1-12) did you complete: History of Learning Disability or Special Ed Classes: YES NO If you graduated high school, what year: If you earned a GED/Diploma, what year:

**Military Service:** Branch: Rank Attained: Date/Type of Discharge: List any **Vocational or Trade Schools** attended: List any **Certifications or Licenses** earned: List any **College(s)** attended: List any **Undergraduate and/or Graduate degrees** earned:

**Currently Working**: YES NO **Employer / Job Title: Unemployed?** YES NO **Retired:** YES NO **Disabled:** YES NO **Receiving Disability Benefits**: YES NO If NOT currently working, **last year worked**: **Stopped due to**: What **type(s) of work have you done most** as an adult: Have you ever been **self-employed**: YES NO Business (es): Have you ever received **Worker’s Compensation**: YES NO Settled ($) a **personal injury suit**: YES NO

**As an adult (18+)** has **religion-spirituality** been important for you: YES NO **Actively Practicing:** YES NO What **kinds of crafts, hobbies, and recreational activities have you done in the past**?

What **kinds of crafts, hobbies, and recreational activities** do you **currently** do on a regular basis**:**

**How many times have you been married**: (use back of page if additional room is needed)

1st marriage lasted years and ended (Year: ) due to 2nd marriage lasted years and ended (Year: ) due to 3rd marriage lasted years and ended (Year: ) due to Number of Children: Current Ages/Location:

**Current Living Situation (check all that apply)**

Living alone

Living with friend(s)

Living with parent(s)

Living with other relative(s)

Living with romantic partner

In a relationship - not living with partner

Married, living with spouse

Married, living with spouse and family

Married, but separated [since ] Other(s) in Household:

**If you ARE currently married or in a relationship, circle all that apply about this relationship:**

|  |  |  |  |
| --- | --- | --- | --- |
| Open Communication | Friendly | Roommates | One-sided |
| Mutually Trusting | Best of Friends | Detached | Tension-Filled |
| Admire My Partner | Comfortable | Broken | Rocky |
| Secure | Fulfilling | Dysfunctional | Unstable |
| Passionate | Intimate | Loveless | Constant arguments |
| Affectionate | Solid | Sexless-Platonic | Not on Speaking Terms |

**If you ARE NOT currently married or in a relationship, circle all that apply to you:**

|  |  |  |  |
| --- | --- | --- | --- |
| Comfortable Alone | Too Busy | Too Picky | Poor Body Image |
| Taking Time Off | Not Interested | Too Distrustful | Afraid of Poor Choice |
| Occasionally Dating | Low Self-Esteem | Too Pessimistic | Financially Unable |
| Actively Looking | Fear of Intimacy | Too Self-Conscious | Cheated On |

**Historically, as a CHILD or TEENAGER, were you ever:**

**Verbally-Emotionally Abused:** YES NO If YES, circle if this happened on an **Isolated** or **Repeated** basis **Physically Abused ……………….:** YES NO If YES, circle if this happened on an **Isolated** or **Repeated** basis **Sexually Abused ………………….:** YES NO If YES, circle if this happened on an **Isolated** or **Repeated** basis

**Historically, as an ADULT (18+), have you ever been**:

Verbally-Emotionally Abused: YES Being Physically Abused: YES Being Sexually Abused: YES

**Are you currently being abused** in any fashion? YES NO

***Mental Health History***

***Mark all mental health conditions for which you have been diagnosed or provided medication:***

***Note “P” for Past; “C” for Current, “PC” for Past & Current.***

Anorexia Panic Disorder

Bulimia Dissociative Disorder

Attention Deficit Disorder (ADD) Depression Disorder

Attn Deficit Hyper Disorder (ADHD) Bipolar Disorder

Traumatic Brain Injury (TBI) Schizoaffective /Schizophrenia

Memory Impairment Alcoholism

Agoraphobia Street Drug Addiction

Anxiety Disorder Prescription Medication Addiction Mental Health Conditions (not listed):

**Current Mental Health Treatment Providers:** None; or

**Medications (with dosages) you are CURRENTLY prescribed for any mental health condition(s)**

(If you have a list which can be copied, it is not necessary to rewrite those medications here)

**Circle the frequency of your current emotional-behavioral symptoms (or leave blank if it does not apply).**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Forgetful / Confusion**: | Occasional | Daily | **Cannot Concentrate**: … | Occasional | Daily |
| **Feel Inadequate**: ……… | Occasional | Daily | **Crying**: ………………. | Occasional | Daily |
| **Anxious-Afraid**: ……… | Occasional | Daily | **Panic Attacks**: ………. | Occasional | Daily |
| **Irritability**: …………… | Occasional | Daily | **Temper Outbursts**: …… | Occasional | Daily |
| **Isolating from Others**: | Occasional | Daily | **Suicidal Thoughts**: …… | Occasional | Daily |

**Check off your current non-pain physical symptoms (or leave blank if it does not apply)**

|  |  |  |
| --- | --- | --- |
| No/Limited Appetite | Difficulty staying asleep | Medication side effects |
| No/Limited Sex Drive | Stomach/ GI problems | Excessive sweating |
| Limited Energy-Stamina | Heart problems |  |
| Difficulty getting to sleep | Breathing problems |  |

**History of Psychiatric / Psychological Treatment:**

**Inpatient Hospitalization(s):** YES NO If YES, # of times Last Hospitalization Date: **History of Suicide Attempts:** YES NO If YES, # of times Last Attempt Date: **History of Self-Mutilation:** YES NO If YES, by : cutting picking hitting Last Date Done: **Outpatient Psychiatric Medication Management:** YES NO **If YES:** Once Multiple Times Consistently **Outpatient Psychotherapy / Counseling:** YES NO **If YES:** Once Multiple Times Consistently

***Circle the frequency of your Pain Problems (Leave blank if it does not apply).***

***Then rate (with an “X”) the usual severity of your pain on a 1*** ** ***10 scale of increasing distress.***

|  |  |  |  |
| --- | --- | --- | --- |
| **Neck / Head Pain**: None | Occasional | Daily | [(1) (5) (10)] |
| **Shoulder-Arm Pain**: None | Occasional | Daily | [(1) (5) (10)] |
| **Stomach-Chest Pain**: None | Occasional | Daily | [(1) (5) (10)] |
| **Mid Back Pain** None | Occasional | Daily | [(1) (5) (10)] |
| **Lower Back Pain**: ….. None | Occasional | Daily | [(1) (5) (10)] |
| **Leg-Foot Pain**: ……… None | Occasional | Daily | [(1) (5) (10)] |
| **Other**: None | Occasional | Daily | [(1) (5) (10)] |

**Historically, your medically diagnosed conditions: “C” for Current; “P” for Past; or leave blank**

Chronic Pain

Chronic Fatigue Syndrome

Fibromyalgia Syndrome

Cancer

Diabetes

GERD (Acid Reflux)

Head Injury (ies)

Seizure (s) -Epilepsy

Stroke (s)

HIV+ (AIDS) Heart Problems

**Historically, surgeries** (with approximate year) you have undergone:

**Historically, do you have a personal history of:**

**Alcohol Abuse:** YES NO **If YES,** beginning ending Last Detox: Have you been in **Alcohol Rehab?** YES NO Participated in AA ? YES NO (Currently: YES NO)

**Substance Abuse:** YES NO **If YES,** beginning ending Last Detox: Have you been in **Substance Abuse treatment?** YES NO

**Street Drugs Abused:** Cannabis Cocaine Crack Heroin Psychedelics Unprescribed Narcotics

**Prescription Medication Addiction:** YES NO **If YES**, begin end **Last Detox: Medications Abused**: Benzodiazepines Stimulants Opioids-Narcotics

**Jail / Imprisonment:** YES NO **If YES, how many times:** Last release date:

**Related to:** Drugs Alcohol Theft Domestic Violence Property Crimes Assault Crimes

***Additional Concerns / Explanation of Symptoms***

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**LEIGH SCOTT ROSENBERG, PSY.D., PLLC; Licensed Psychologist (PY3608) 2973 West SR 434, Suite 400 Longwood, Florida 32779**

**Telephone / Fax: 407-362-5930 Website:** [**www.activecoping.com**](http://www.activecoping.com/)