| | | |
|---|---|---|
| | **ADULT PSYCHOTHERAPY QUESTIONNAIRE**<br>**(use the back of any page to add information)** | Date<br>_____ |

**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 | Stepfather | Uncle |
| Father | Adoptive Mother | Aunt Grandparent(s) |
| Stepmother | Adoptive Father | Foster Parent(s) |

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

| | | |
|---|---|---|
| Only Child | Half Sister (s) _____ | Adopted Sibling (s) |
| Full Sister (s) _____ | Half Brother (s) _____<br>Step Sister(s) _____ | _____ |
| Full Brother(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
_____Bulimia
_____Attention Deficit Disorder (ADD)
_____Attn Deficit Hyper Disorder (ADHD)
_____Traumatic Brain Injury (TBI)
_____Memory Impairment
_____Agoraphobia
_____Anxiety Disorder
_____Panic Disorder
_____Dissociative Disorder
_____Depression Disorder
_____Bipolar Disorder
_____Schizoaffective /Schizophrenia
_____Alcoholism
_____Street Drug Addiction
_____Prescription Medication Addiction

Mental Health Conditions (not listed): _____

**Names of Current/Previous Mental Health Providers:** None; or

_____ _____

**Current medications (with dosages) 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
_____No/Limited Sex Drive
_____Limited Energy-Stamina
_____Difficulty getting to sleep
_____Difficulty staying asleep
_____Stomach/ GI problems
_____Heart problems
_____Breathing problems
_____Medication side effects
_____Excessive sweating
_____ _____
_____ _____

**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 "X's") the daily severity range 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)]

**Your history of medically diagnosed conditions: "C" for Current; "P" for Past; or leave blank**

| | | |
|---|---|---|
| ___Chronic Pain | ___Cancer | ___Head Injury (ies) |
| ___Chronic Fatigue Syndrome | ___Diabetes | ___Seizure (s) -Epilepsy |
| ___Fibromyalgia Syndrome | ___ Heart problems | ___Stroke (s ) |

**Currently prescribed pain related medications: _____**

_____

**History of surgery(ies)** (with approximate year) for pain conditions: _____

_____

**Alcohol Abuse history:** 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 history:** 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 history:** YES NO **If YES**, begin end _____ **Last Detox:** _____

**Medications Abused**: Benzodiazepines Stimulants Opioids-Narcotics _____

**Jail / Imprisonment history:** 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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