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Office within Triangle Center for Behavioral Health
Adult Questionnaire

Client Information:

Name:_____ Age: _____ Date of Birth:___ __/____/_____

Address:_____

City:_____ State/Province:_____ Zip/Postal Code:_____

Primary Phone: _____ Alternate Phone: _____

Email:_____

Insurance Information (if you will be seeking reimbursement):

Insurance CompanyName_____

Client's ID Number: _____ Group Number: _____

Subscriber Name: _____

Subscriber Date of Birth: _____ Subscriber Relation to Client:_____

Subscriber Employer: _____

Today's Date: _____

Please briefly explain why you are seeking an evaluation and/or therapy:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Family Information

Marital Status: □ Single □ Married: How long? _____

□ Divorced: How long? _____□ Separated How long? _____ □ Widow How long?_____

Please describe previous marriage(s), if any:

_____

_____

_____

Do you have children? □ Yes □ No If so, how many? _____

If divorced who has custody? □ Mother □ Father □ Joint Custody □ Neither Specify:

Are any of your children adopted? □ Yes □ No

If yes, please describe the circumstances of the adoption:

_____

_____

_____

Have you lost a child? □ Yes □ No

If yes, please describe the circumstance of your loss:

_____

_____

_____

Do any of your children have special needs? □ Yes □ No

If yes, please describe your child's needs:

_____

_____

_____

Please list all children and other adults living in your home:

Name	**Age**	**Relationship**

Do you have a history of violence in your house or in your relationships? □ Yes □ No

Is anyone that you are in a close relationship with abusing drugs and/or alcohol? □ Yes □ No

Please describe the circumstances of any of the above if marked yes:

_____
_____
_____
_____

Father's Name:_____□ Living □ Deceased

Mother's Name:_____□ Living □ Deceased

Are/were your parents divorced? □ Yes □ No

Is more than one language spoken in your home? □ Yes □ No

If yes, what is the primary language spoken in your home? _____

Early Developmental History

If don't know pregnancy history due to adoption, please check here: □

Was your mother's pregnancy under a doctor's care? □ Yes □ No □ Don't know

Check any that apply:	Describe/Treatment
□ Artificial Insemination Donor	_____
□ Anemia	_____
□ Elevated Blood Pressure	_____
□ Toxemia	_____
□ Swollen Extremities	_____
□ Kidney Disease	_____
□ Bleeding/Threatened Miscarriage	_____
□ Measles/German Measles	_____
□ Flu	_____
□ Strep Throat	_____
□ Other Virus/Illness/Injury	_____
□ Abnormal Nausea or Vomiting	_____
□ Medication(s) Taken	_____
□ Emotional Problems/Distress	_____
□ Premature Labor	_____
□ Smoked During Pregnancy	_____

□ Drank Alcohol During Pregnancy _____

Please describe any complications that occurred during your mother's pregnancy:_____

_____

_____

_____

If don't know birth history due to adoption, please check here: □

Mother's age at the time of your birth: _____Father's age at the time of your birth: _____

Your Birth weight? ____lbs.____oz. Was birth a multiple? □ No □ Yes, how many:

Was birth complicated by:	Describe
□ Prematurity	_____
□ Unplanned Induced Labor	_____
□ Breech presentation	_____
□ Cesarean section	_____
□ Unusual anesthesia	_____
□ Other	_____

Following birth, were there complications related to:

□ Breathing problems	_____
□ Need for oxygen	_____
□ Blue color	_____
□ Meconium	_____
□ Cord around the neck	_____
□ Jaundice/yellow color	_____
□ Feeding problems	_____
□ Maternal health	_____

Did these complications result in an extended hospital stay? □ No □ Yes, how long:____

How would you describe the following?

Motor Development (Sitting, Walking)	□ Normal	□ Fast	□ Slow
Speech and Language	□ Normal	□ Fast	□ Slow
Self-help Skills (dressing, toileting, hygiene)	□ Normal	□ Fast	□ Slow

Please describe any specific concerns that were noted during your early development:

_____

_____

_____

Did you undergo any evaluations as a child? □ Yes □ No

If yes, please describe the outcome of the evaluation (provide copies of the evaluation if possible):_____

_____

Medical History

Have you had any of the following?

	No	Yes	Date/Age/Description
Measles	□	□	_____
Mumps	□	□	_____
Rubella	□	□	_____
Migraine	□	□	_____
Severe Abdominal Pain	□	□	_____
Cancer	□	□	_____
Chicken Pox	□	□	_____
Whooping Cough	□	□	_____
RSV	□	□	_____
Severe Flu	□	□	_____
Strep Throat	□	□	_____
Meningitis/Encephalitis	□	□	_____
Constipation	□	□	_____
Urinary Tract Infections	□	□	_____
Abscessed Ears	□	□	_____
Tubes in Ears	□	□	_____
Allergies	□	□	_____
Asthma	□	□	_____
Seizures	□	□	_____
Head Injuries	□	□	_____
Other Injuries	□	□	_____
Hospitalizations	□	□	_____
Hearing Problems	□	□	_____
Vision Problems	□	□	_____
Other	□	□	_____

Please list any significant childhood illnesses:

_____
_____

Please list any surgery and when it was performed:

_____
_____

Have you ever had a seizure, head trauma, or loss of consciousness? □ Yes □ No

If so, please describe:

_____
_____

Have you ever been hospitalized? □ Yes □ No

If so, please describe:

_____
_____

Have you ever been seen in the emergency room? □ Yes □ No

If so, please describe:

_____
_____

Are you currently receiving treatment for a medical condition? □ Yes □ No

If so, please describe:

_____
_____
_____
_____
_____

Are you currently taking any non-psychiatric medications? □ Yes □ No

Medication	Dosage	Dates of Use	Prescriber

Do you engage in regular exercise/physical activity? □ Yes □ No

Are you happy with your current weight/level of fitness? □ Yes □ No
If no, why not

_____

Describe your sleep: □ Excessive □ restless □ Insomnia □ Fatigued □ No Difficulties

Substance Use History

Do you currently smoke? □ Yes □ No If yes, how many a day?_____

Do you use smokeless tobacco? □Yes □No

Have you ever or are now trying to stop smoking or using tobacco? □Yes □No

If yes, please describe your efforts:

_____

_____

How often do you drink alcohol? □ Never □ Monthly □Weekly □ Daily

Have you ever been or are you now concerned about how much you drink? □Yes □No

If yes, please describe your concerns:

_____

_____

Do you regularly use street drugs or misuse/abuse prescription drugs ? □ Yes □ No

If yes, please describe what you use and how often:

_____

_____

Has there been a time in the past when you regularly used street drugs or misuse/abuse prescription drugs ? □Yes □ No If yes, please describe what you used and how often:_____

_____

Have you ever sought treatment for a drug use problem or addiction ? □ Yes □ No If yes, please describe:_____

_____

_____

Family Medical/Psychiatric History

Do any medical illnesses run in the family? (Example: seizures, thyroid problems)

□ Yes □ No □ Don't know

If yes, please describe whom/illness/treatment: _____

_____

_____

_____

_____

Have any of your **biological relatives** had mental health problems? □ No □ Yes □ Don't know
If yes, which of the following conditions?

□Major Depression □ Bipolar Disorder □ Obsessive-Compulsive Disorder

□ ADHD/ADD □ Tic Disorders □ other Anxiety Disorders

□ Schizophrenia □ Substance Abuse □ Suicide Attempts

□ other psychiatric problems (Describe:_____)

In which biological relative(s)?

□ Mother □ Father □ Brother □ Sister

□ Grandmother(paternal/maternal) □ Grandfather(paternal/maternal)

□ Aunt/uncle (paternal/maternal) □ Uncle (paternal/maternal)

□ Other (Specify: _____)

Please further describe any family psychiatric problem(s), including treatment: _____

_____

_____

Outside of biological relatives, are there **any other people with whom you have significant contact** who has medical or psychiatric problems? □ Yes □ No □ Don't know
If yes, please describe: _____

_____

_____

_____

_____

Academic History

If you are currently a student:

Name of School: _____ Year:_____

Performance: □ Poor □ Fair □ Good

Highest degree completed to date: □ High School □ College □ Graduate/professional

□ Technical Training □ Other _____

Any known learning disabilities/attention problems? □ Yes □ No

If Yes, when were you diagnosed and explain specific disabilities (Please provide copies of testing if possible) :

_____

_____

_____

Work Information

Are you currently employed? □ Yes □ No Occupation _____

Employer:_____How long with this employer? _____

How would you describe your current level of job satisfaction?

□ Very Satisfied □ Satisfied □ Average □ Dissatisfied □ Very Dissatisfied

If you are not currently employed, which of the following describes you?(check all that apply)

□ Student □ Retired □ Looking for work □ Stay-at-home parent

□ Caring for sick/elderly relative □ Volunteer □ Other _____

□ **Social Functioning**

□ Which of the following, if any, describe(s) your interactions with peers/colleagues?

□ No friends	□ Average number of friends	□ Trouble keeping friends
□ Few Friends	□ Socially comfortable	□ Trouble making new friends
□ Controlling	□ Aggressive	□ Bullying
□ Excessively shy	□ Overall social	□ Socially awkward

ExtracurricularActivities: _____

_____

_____

Further comments on social functioning:

_____

_____

_____

Therapy History

Has you ever received:

Mental health-related therapy?	□ Yes	□ No	□ Don't know
Cognitive-Behavioral Therapy (CBT)?	□ Yes	□ No	□ Don't know
Family Therapy?	□ Yes	□ No	□ Don't know
Group Therapy?	□ Yes	□ No	□ Don't know
Speech/language Therapy?	□ Yes	□ No	□ Don't know
Physical or occupational Therapy?	□ Yes	□ No	□ Don't know
Developmental Therapy?	□ Yes	□ No	□ Don't know
Play Therapy?	□ Yes	□ No	□ Don't know

Please describe any previous therapy, including dates or age when attended and reason for the therapy:

_____

_____

_____

_____

_____

_____

_____

Have you ever taken psychiatric medication?□Yes □ No □ Don't know

If yes, please complete the following:

Medication	Dosage	Dates of Use	Prescriber	Benefits	Side Effects

Is there anything else you would like me to know about you?

_____

_____

_____