

Psychological and Consultation Services, P. C.
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Adult Patient Questionnaire

Patient Information

Please complete the following questions. This form will help us know and understand as much as possible about you and your situation in order to develop and provide treatment to meet your specific needs.

Today's Date: _____

Person Completing Questionnaire: _____ Relationship to Patient: _____

Patient Name: _____

Sex: ☐ Male ☐ Female Other: _____ Social Security Number: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Country: _____

Cell Phone: (____) _____ - _____ Home Phone: (____) _____ - _____ Business Phone: (____) _____ - _____
Email: _____

Date of Birth: _____ Age: _____ Place of Birth: _____

Eye Color: _____ Hair Color: _____ Height: _____ Weight: _____

Hand Preference: ☐ Right ☐ Left

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: (____) _____ - _____ Home Phone: (____) _____ - _____ Business Phone: (____) _____ - _____

Current Marital Status:

☐ Married - Years Married: _____ ☐ Widowed ☐ Separated ☐ Divorced ☐ Never

Married

☐ Permanent Partner – Years: _____

Race/Ethnic Group:

☐ Native American – Tribe: _____ ☐ Asian – Ethnic Group: _____

☐ Hispanic – Ethnic Group: _____ ☐ Black – Ethnic Group: _____

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☐ White – Ethnic Group: _____ ☐ Other: Ethnic Group _____

Highest Grade Completed:

- ☐ 8th grade or less ☐ Some High School
☐ High School Graduate/GED ☐ Some College/Specialized Training: _____
☐ College Graduate – University & Degree: _____
☐ Graduate of Professional School: Degree: _____
☐ Unknown

Employment Status:

- ☐ Part-Time ☐ Full Time ☐ Laid Off ☐ Armed Forces ☐ Retired ☐
Volunteer
☐ Temporary ☐ Self-Employed ☐ Unemployed ☐ Fired ☐
Other: _____

Occupation:

Job title: _____

What kind of work activities and duties do you perform?

Do you work for: ☐ Private Company ☐ Government ☐ Self (own business) ☐ Family business
without pay

Veteran Status:

- ☐ Active Military ☐ Active Reserve ☐ Discharged ☐ Not a Veteran

Physical Health:

- ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Emotional Health:

- ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Presenting Problems/Symptoms/Goals

Describe the problem(s) you are seeking help for at this time: _____

Family Stressors: Are there any stressors that are affecting you and your family?

☐ No ☐ Yes If yes, please explain: _____

What improvements would you like to see as a result of treatment? _____

Are there cultural, religious, or spiritual considerations that should be considered in treatment planning?

☐ No ☐ Yes If yes, explain: _____

Reason for Referral

Who referred you?

Listed below are a number of categories in which people commonly find some difficulties. Please indicate how you are affected in each area by circling the appropriate number (please circle only one number for each item).

Not a Problem	Somewhat a Problem	Moderate Problem	Serious Problem	Severe Problem
1	2	3	4	5

Your Physical Functions

Sleep Pattern	1	2	3	4	5
Eating Problem	1	2	3	4	5
Bladder Control	1	2	3	4	5
Bowel Control	1	2	3	4	5
Seizures, Convulsions	1	2	3	4	5
Speech (stuttering or stammering)	1	2	3	4	5
Weight Problem	1	2	3	4	5
Sexual Functioning	1	2	3	4	5
Balance	1	2	3	4	5

Your Experience at Work

General Performance	1	2	3	4	5
General Satisfaction	1	2	3	4	5
Lateness	1	2	3	4	5
Absenteeism	1	2	3	4	5
Negative Feelings about Work	1	2	3	4	5
Relating to Supervisors	1	2	3	4	5
Relating to Co-workers	1	2	3	4	5
Relating to Subordinates	1	2	3	4	5

Your Inner Thoughts and Ideas

Thoughts about Hurting Yourself	1	2	3	4	5
Thoughts about Hurting Others	1	2	3	4	5
Unwanted Thoughts	1	2	3	4	5
Worrying about Health	1	2	3	4	5
Feeling Inferior	1	2	3	4	5
Seeing Things without Apparent Cause	1	2	3	4	5
Hearing Things without Apparent Cause	1	2	3	4	5
Experiencing Confusion	1	2	3	4	5
Problems with Memory	1	2	3	4	5

Your Feelings and Moods

Depression	1	2	3	4	5
Euphoria	1	2	3	4	5
Sudden Mood Swings (feeling high)	1	2	3	4	5
Nervousness	1	2	3	4	5
Lack of Energy	1	2	3	4	5
Not Liking Self	1	2	3	4	5
Not Liking Others	1	2	3	4	5

Your Behavior

Difficulty with Daily Routine	1	2	3	4	5
Letting Others Take Advantage of You	1	2	3	4	5
Hyperactivity (can't sit still)	1	2	3	4	5
Repeating Certain Acts	1	2	3	4	5
Physically Abusing Others	1	2	3	4	5
Using Alcohol to Cope with Problems	1	2	3	4	5
Lying	1	2	3	4	5
Stealing	1	2	3	4	5
Withdrawal from Others	1	2	3	4	5
Overly Dependent	1	2	3	4	5
Overly Suspicious	1	2	3	4	5
Hostility	1	2	3	4	5
Problems with Spouse	1	2	3	4	5
Problems with Children	1	2	3	4	5
Problems with Friends	1	2	3	4	5

Have you ever been physically abused?	☐ Yes	☐ No
Have you ever been sexually abused?	☐ Yes	☐ No
Have you ever thought about committing suicide?	☐ Yes	☐ No
Have you ever told anyone you would commit suicide?	☐ Yes	☐ No
Have you ever been so angry that you felt you might kill someone?	☐ Yes	☐ No
If you have responded yes to any of the above questions, please explain: _____		

Prior Mental Health Services

Have you ever received counseling or psychiatric treatment in the past? ☐ Yes ☐ No

(If no, skip the questions in this section and go on to the next section.)

If yes, please answer the following questions:

In all, how much time have you spent in counseling?

☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ 12-18 months ☐ 18-24 months ☐ More than 2 years

How long ago were you in counseling or treatment?

☐ In treatment now ☐ Less than 3 months ago ☐ 3-6 months ago ☐ 6 months - 1 year ago ☐ More than 1 year ago

☐ Other: _____

List psychiatric hospitals, treatment with centers, or medical hospitals with psychiatric units you have been in:	Dates of Hospitalization	Problems/Diagnosis/Reason	Satisfied treatment
1. _____ No	_____	_____	☐ Yes ☐
2. _____ No	_____	_____	☐ Yes ☐
3. _____ No	_____	_____	☐ Yes ☐

List other day treatment or partial with hospital programs you were in:	Dates of Treatment	Problems/ Diagnosis/ Reason	Satisfied treatment
1. _____ No	_____	_____	☐ Yes ☐
2. _____ No	_____	_____	☐ Yes ☐
3. _____ No	_____	_____	☐ Yes ☐

List name(s) of outpatient therapists with you have received treatment from:	Dates of Treatment	Problems/Diagnosis/Reason	Satisfied treatment
1. _____ No	_____	_____	☐ Yes ☐
2. _____ No	_____	_____	☐ Yes ☐
3. _____ No	_____	_____	☐ Yes ☐

Type of Outpatient you received:

☐ Individual Counseling ☐ Group Counseling ☐ Family Counseling ☐ Intensive Counseling (2-3 years)
☐ Other: _____

If in outpatient therapy, how many sessions did you attend?

☐ 1 or 2 sessions ☐ 3-10 sessions ☐ More than 10 sessions

How often did you miss scheduled sessions?

☐ Never ☐ Less than ½ of the time ☐ More than ½ of the time ☐ Almost all the time

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Please list any medications that you have been treated with in the past for anxiety, mood, or behavioral problems:

Medication	Duration	Response/Side Effects
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Chemical Use History

Caffeine: Cups per day?

Coffee ☐None ☐1 ☐2 ☐3 ☐4 ☐5 ☐More
 Tea ☐None ☐1 ☐2 ☐3 ☐4 ☐5 ☐More
 Cola ☐None ☐1 ☐2 ☐3 ☐4 ☐5 ☐More

Cigarettes:

Do you smoke? ☐No ☐Yes If so, how many packs a day, week, month, or year?

Cigars:

Do you smoke? ☐No ☐Yes If so, how many a day, week, month, or year?

If you currently use drugs or have used drugs in the past, please fill in the following blanks:

Substance	No	Yes	Amount	How Often	Age/Date First Used	Date Last Used
Alcohol	☐	☐	_____	_____	_____	_____
Marijuana	☐	☐	_____	_____	_____	_____
Speed/Amphetamines	☐	☐	_____	_____	_____	_____
Cocaine	☐	☐	_____	_____	_____	_____
LSD	☐	☐	_____	_____	_____	_____
Prescription	☐	☐	_____	_____	_____	_____
Other: _____	☐	☐	_____	_____	_____	_____

Number per week of: Beers: _____ Wine: _____ Mixed Drinks: _____

Number of times for Marijuana use: Per Day: _____ Per Week: _____ Per Month: _____

Which of the following reactions have you had as a result of substance use/abuse?

☐ Anger/Violence	☐ Guilt/Self-Respect	☐ Conflict with Family or Friends
☐ Legal Problems	☐ Job/School Problems	☐ Financial Problems
☐ Health Problems	☐ DUI	☐ Blackouts
☐ Seizures	☐ Withdrawal	☐ Depression
☐ Other: _____		

Have you sought treatment for drug abuse? ☐No ☐Yes

If yes, please explain and give the results: _____

Do you consider the drug abuse a problem? ☐No ☐Yes

Are you addicted to the substance? ☐No ☐Yes

How motivated are you to change? ☐None ☐A Little ☐Somewhat ☐A Lot

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Legal History

Have you ever been arrested? ☐ No ☐ Yes If yes, please explain:

Were charges filed? ☐ No ☐ Yes If yes, what charges?

Are you pending court now? ☐ No ☐ Yes

Disposition of Charges:

Are you currently on probation? ☐ No ☐ Yes

If so, give the name of the probation/parole officer:

Health History

Are you currently experiencing any of the following?

- | | |
|---|---|
| ☐ Abdominal Pain | ☐ Backache |
| ☐ Chest Pain | ☐ Colitis |
| ☐ Difficulty Sleeping | ☐ Eye Problems |
| ☐ Hearing Problems | ☐ Hypertension |
| ☐ Palpitations | ☐ Problems with Skin |
| ☐ Ulcers | ☐ Vomiting |
| ☐ Shortness of Breath | ☐ Hypoglycemia |
| ☐ Change in Menstrual Cycle | ☐ Change in Urinary Pattern |
| ☐ Gastrointestinal Problems | ☐ Loss of Sexual Interest |
| ☐ Change in Bowel Habits | ☐ Loss or Increase in Appetite |
| ☐ Cough | ☐ Headache |
| ☐ Problems with Muscles, Joints, Bones | ☐ Other: _____ |

List any medications you are now taking, even only occasionally:

Name of Medication	Dosage	Reason for Taking
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Primary Care Physician:

Date of your last Physical Examination:

His/Her Address: _____ Phone #: _____

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If you have ever been hospitalized, please complete the following:

Hospital/Location:

Year:

Nature of Problem:

1. _____
2. _____
3. _____

Family History

How many brothers and sisters do you have?

Brothers: _____ Step Brothers: _____ Half Brothers: _____

Sisters: _____ Step Sisters: _____ Half Sisters: _____

None: ☐

Age(s) of Brothers: _____ Age(s) of Sisters: _____

Mental Health History: Brother(s): _____ Mental Health History: Sister(s): _____

How many children do you have? None: ☐ Boys: _____ Girls: _____

Age(s) of sons: _____ Age(s) of daughters: _____

Mental Health History: Son(s): _____ Daughter(s): _____

Check the adults that have been living in your home during the last three months:

☐ Spouse ☐ Mother ☐ Father ☐ Mother-In-Law ☐ Father-In-Law

☐ Sister ☐ Brother ☐ Friend ☐ Permanent Partner ☐ Other: _____

For any relatives that have experienced any of the following problems, please check the boxes that apply:

(It may be easier to fill out the following table if you write the name of the relative in the areas below each category)

[illegible]

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Problem: Biological Family- Continued			Mother's Father	Mother's Mother	Father's Father	Father's Father	Father's Father	Father's Brothers/ Sisters	Your Brothers/ Sisters
Has Taken Medication for Psychiatric Illness									
Spent Time in a Psychiatric Hospital									
Been Involved In Criminal Behavior									
Sleeping Disturbances that were Ongoing									
Victim of Sexual Abuse									
Sexual Abuser									
Spent Time in Prison									
Convicted of a Sexual Offense									
Eating Disorder									

Describe any other relevant family issues:

Level of Functioning

Have you experienced any difficulties at work?

☐ No

☐ Yes

If yes, please explain:

Have you experienced any difficulties at home?

☐ No

☐ Yes

If yes, please explain:

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Have you experienced any difficulties in your relationship with your spouse?

☐ No ☐ Yes

Have you experienced any difficulties in your relationships with your children?

☐ No ☐ Yes

Have you experienced any difficulties in your relationships with your friends?

☐ No ☐ Yes

If you answered yes to any of the questions above, please explain:

Is there any additional information that you feel would be helpful in understanding your current problem(s) and/or concerns?

Do you have any concerns regarding the scheduling of your first appointment? _____

THANK YOU FOR YOUR HELP IN COORDINATING YOUR CARE