1216 Duncan Rd
Copperas Cove, TX 76522
254-577-4880

Adult History Questionnaire

Name: ____ Date: ___________________________

Completed by: ____ Gender: _________________________

DOB: _________________________ Age: _______________________

Ethnicity/Race:

__________ African American __________ B-racial __________ Hispanic/Latino __________ Pacific Islander

__________ Asian American __________ White/Caucasian __________ Native American __________ Other

If other, please describe: ____

Previous Counseling

Are you presently receiving counseling elsewhere? YES NO

(If yes, do not complete this form until you have talked with your counselor)

Have you ever seen a mental health professional (psychiatrist, psychologist, or counselor?) YES NO

If yes, please provide dates of service:

____

____

(If yes, we may need your permission in order to communicate with that individual or agency)

Have you ever been hospitalized for mental health concerns: YES NO

If yes: When: _____________________________________ Where: __________________________________

Are you seeking services because you are a victim of a crime? YES NO

Did it result in legal action? YES NO If yes, please explain:

____

Educational/Work History:

What is the last grade you completed, including GED? ________________________________

Occupation: ____

Where do you work? ____

How long have you worked there? ____

Marital Status:

Marital Status:

_____ Married _____ Divorced _____ Widowed _____ Separated _____ Never Married

How long married? ____

Number of previous marriages? ________

Family:

Current living arrangements:

_____ Family of Origin _____ Single _____ Spouse/Partner _____ Roommate _____ Cohabiting

_____ Other

List names, ages and gender of children in the home.

Name	Age	Gender	Relationship to You

Religion/Spirituality:

Does religious faith play an important part in your life? YES NO

If so, what faith based community do you belong/attend: ____

Health History:

Are you presently being treated by a physician for any medical conditions? YES NO

If so, please describe:

____

____

Physical disability: YES NO If yes, explain ____

____

Check any of the following items that apply:

_____ Depression _____ ADHD _____ ADD _____ Conduct Disorder _____Anxiety/Nervousness

_____ Bipolar Disorder _____ Schizophrenia _____ Oppositional Defiant Disorder

_____ Mood/Anger _____ Tics _____ Insomnia/Sleeplessness _____ Obsessive/Compulsive

_____ Seizures _____ Post Traumatic Stress Disorder Other: ______________________________

List medications you are currently taking:

____

____

Circle the item that you see as the most significant issues. Check any that apply.

Problems Related to Abuse

_____ Current or past physical abuse

_____ Current or past sexual abuse

_____ Current or past emotional abuse

_____ Current or past neglect

_____ History of abandonment

_____ Suspected sexual abuse

_____ Current or past family domestic violence

Behavior Concerns:

_____ Aggression towards others

_____ Drug/Alcohol use

_____ Outbursts of anger

_____ Gender identity concerns

_____ Inappropriate sexual behavior

_____ Intentionally hurting others

_____ Hyperactive/Inattentive

Mood-related Concerns:

_____ Disturbing memories

_____ Difficulty going to sleep/staying asleep

_____ Nightmares/night terrors

_____ Suicidal Ideations

_____ Sadness/Depression

_____ Feelings of guilt and shame

_____ Excessive Worrying

Family Relationship Concerns:

_____ Difficulty adjusting to family changes

_____ Marital concerns

_____ Parent-child relationship problems

_____ Sibling concerns

_____ Divorce/Separation

_____ Grief/Loss

When did you first become concerned about the main/most significant issues?

____

How have you attempted to cope/deal with this issue before now?

____

Legal History:

List any prior trouble you may have had with civilian police/authorities, including juvenile offenses. (Exclude minor traffic violations, etc.) ____

____

List of current legal troubles (including involvement in CPS):

____

____

Does any family member have current legal troubles?

____

Chemical Health

Describe any current or history of alcohol or drug use.

____

____

____

Have you ever felt you ought to cut down on your drinking or drug use? YES NO

Have people annoyed you by criticizing your drinking or drug use? YES NO

Have you ever felt bad or guilty about your drinking or drug use? YES NO

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? YES NO

Family Mental Health History

Please identify if any members of your family have had a history of any of the following mental health concerns:

Depression: ____

Anxiety: ____

Bipolar Disorder: ____

Schizophrenia: ____

ADHD/ADD: ____

Trauma History: ____

Alcohol Abuse: ____

Drug Abuse: ____

Incarceration: ____

What would you like to see come out of services for yourself?

____

____

____

Is there any other information that would be helpful to know in helping you?

____

____

____

Individual completing form:

Printed Name: ____ Date: _______________

Signature: ____