ADULT CLINICAL QUESTIONNAIRE

NAME OF CLIENT: _____ **DATE:**_____

GENDER: _____ **DOB:**_____ **AGE:** _____

MARITAL HISTORY (Married, Single, Divorced): _____

NUMBER OF CHILDREN: _____

AGES OF CHILDREN: _____

SOURCE OF INFORMATION: _____

PRIMARY CARE PHYSICIAN: _____

PSYCHIATRIST: _____

REASON FOR REQUESTING THERAPY?_____

_____

_____

WHAT WOULD YOU LIKE TO GET OUT OF COUNSELING?_____

_____

PAST COUNSELING HISTORY:

Where: _____

By Whom: _____

Reason for Counseling:_____

How Long: _____

Did you find counseling beneficial and was it a positive experience? (Please explain)

_____

_____

_____

© Copyright of form belongs to A New Beginning Adoption Agency/Wellness Center. Replication or reuse is prohibited without permission from A New Beginning Agency.

ADULT CLINICAL QUESTIONNAIRE

PAST PSYCHIATRIC HISTORY/DIAGNOSIS: _____

_____

_____

PAST PSYCHIATRIC HOSPITALIZATIONS: _____

_____

PAST SUICIDE ATTEMPTS: _____

_____

DO YOU HAVE ACCESS TO EXCESSIVE AMOUNTS OF MEDICATIONS? _____

_____

DO YOU HAVE ACCESS TO WEAPONS? _____

ARE THERE OTHER SAFETY CONCERNS? _____

_____

ABUSE HISTORY (Physical, sexual, or emotional; please describe):_____

_____

_____

_____

DRUG AND ALCOHOL HISTORY:

Present Drug/Alcohol Intake (please list which drugs or alcohol; frequency; how much):

_____

_____

Past Drug/Alcohol History (please list when, what): _____

_____

© Copyright of form belongs to A New Beginning Adoption Agency/Wellness Center. Replication or reuse is prohibited without permission from A New Beginning Agency.

ADULT CLINICAL QUESTIONNAIRE

Past treatment history for drugs/alcohol (where, when, how long): _____

_____

Is there a family history of substance abuse? (Who): _____

_____

PAST MEDICATION HISTORY: (Please list names of medications, frequency, dosage, physician who prescribed the medication): _____

_____

_____

_____

CURRENT MEDICATIONS: (Please list names of medications, frequency, dosage, physician who prescribed the medication): _____

_____

_____

LEGAL HISTORY: (Current and past): _____

_____

_____

_____

FAMILY PSYCHIATRIC HISTORY:

Is there a family history of depression, anxiety, bipolar, schizophrenia, ADHD, or other related diagnosis? (Please explain): _____

_____

_____

© Copyright of form belongs to A New Beginning Adoption Agency/Wellness Center. Replication or reuse is prohibited without permission from A New Beginning Agency.

ADULT CLINICAL QUESTIONNAIRE

Has a family member been hospitalized for mental illness or substance abuse? (Please explain):

_____

_____

Is there a family history of suicide attempts or completed suicide: (Please explain):

_____

_____

PLEASE CIRCLE THE LETTER OF ALL THAT APPLY:

1. **SLEEPING:**
   A. Do you have difficulty going to sleep?
   B. Do you have difficulty staying asleep?
   C. Do you stay up and not sleep for 2-3 days at a time or more?
   D. Do you sleep more than the average person?

2. **MOOD:**
   A. Do you experience sudden mood swings or mood instability?
   B. Experience irritability, aggression towards others, or have outbursts of anger?
   C. Do you spend money impulsively?
   D. Are you currently or have you experiences in the past promiscuous behaviors (sleeping with multiple partners or with people you hardly know)?
   E. Experience feelings of grandiosity or believing you are better than others or believe you can accomplish more than humanly possible?
   F. Experience extreme feelings of sadness?
   G. Experience increased or decreased appetite?

© Copyright of form belongs to A New Beginning Adoption Agency/Wellness Center. Replication or reuse is prohibited without permission from A New Beginning Agency.

H. Avoid people or isolate?
I. Experience fatigue?
J. Cry more than usual?
K. More emotional at times?
L. Experience suicidal thoughts?
M. Experience low self-esteem?
N. Experience feelings of depression?
O. Have times when you use drugs or alcohol more frequently?
P. Experience nightmares?
Q. Experience flashbacks?
R. Experience feelings of hopelessness, worthlessness, or helplessness?
S. Have no motivation?
T. Struggle with making good decisions?
U. Experience hearing voices or sees things other people do not experience?
V. Struggle with paranoia?

3. OTHER SYMPTOMS:

A. Experiencing heart racing?
B. Dizziness?
C. Experience feelings of wanting to fight or wanting to take flight?
D. Heart pounding?
E. Difficulty breathing?
F. Chest heaviness or pressure?
G. Feeling of dissociation or depersonalization?
H. Have a fear of dying?
I. Chills or hot flashes?
J. Sweating, trembling, or shaking?

© Copyright of form belongs to A New Beginning Adoption Agency/Wellness Center. Replication or reuse is prohibited without permission from A New Beginning Agency.

K. Feelings of choking?
L. Numbness?
M. Have difficulty focusing?
N. Have difficulty staying on task?
O. Have difficulty concentrating?

© Copyright of form belongs to A New Beginning Adoption Agency/Wellness Center. Replication or reuse is prohibited without permission from A New Beginning Agency.