



Comprehensive Adult Questionnaire

Name: _____ **Date:** _____

Presenting Problem

What are the main problems or symptoms that caused you to seek help now? _____

Describe any stresses in your life that may have contributed to the problem: _____

Describe the history of the problem from its onset until now: _____

Have you had a similar problem in the past? Yes No If so, please describe the episodes and the dates they occurred.

Were you treated for this problem? Yes No If so, please describe the treatment you received.

Has this problem caused you to experience any decrease in your ability to function in the following areas?
If so, please describe:
School performance: _____

Work performance: _____

Relationship with spouse/significant other: _____

Functioning as a parent: _____

Social life: _____

Ability to manage chores at home: _____

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Medical History

Please list all medications you are currently taking:

Prescription Medication	Dose	Start Date (MMYY)

Please list any health problems: _____

Mental Health History

Please list any Psychiatrist/Psychologist/Therapist you have seen previously:

Name	Dates Seen	Reason	Medications Prescribed

Have you ever attempted suicide? Yes No If yes, please describe the nature of the event and the date(s) of occurrence. _____

Please list any blood relatives who have any history of mental or emotional problems (e.g. depression, manic depression, alcoholism, drug abuse, suicide, schizophrenia, anxiety problems, eating disorders, Attention Deficit Disorder, etc.)

Relative	Problem

Substance Use:

Do you use any of the following?

Substance	Yes	No	Amount	Frequency:	Daily	Weekly	Date last used
Tobacco	—	—	_____		—	—	_____
Caffeine	—	—	_____		—	—	_____
Alcohol	—	—	_____		—	—	_____
Marijuana	—	—	_____		—	—	_____
Cocaine	—	—	_____		—	—	_____
Amphetamines	—	—	_____		—	—	_____
LSD	—	—	_____		—	—	_____
Heroin	—	—	_____		—	—	_____
Pain Killers	—	—	_____		—	—	_____
IV Drug Use	—	—	_____		—	—	_____



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Have you ever felt that you were abusing drugs or alcohol? Yes No If so, please describe when and the nature of the problem. _____

Have you tried to stop drinking? Yes No If yes, what was the outcome? _____

Have you ever attended AA? Past Current If yes, do you have a sponsor and how often do you attend meetings? _____

Have you ever attended NA? Past Current If yes, do you have a sponsor and how often do you attend meetings? _____

Family/Social History

Where were you born and raised? _____

Please list your siblings and their current ages: _____

Are you close to your siblings? _____

How would you describe your relationship with your father? _____

How would you describe your relationship with your mother? _____

Describe your childhood: _____

Were your parents divorced? Yes No If yes, how old were you? _____

With whom did you live after the divorce? _____

Did your mother remarry? Yes No Did your father remarry? Yes No

What was your relationship like with the stepparent(s)? _____

Were you ever subjected to any type of abuse (emotional, physical, sexual)? Yes No

If yes, please describe the events and ages the abuse occurred. _____

Have you lost a close family member or friend? Yes No Who? _____

When? _____

Educational History

Did you complete high school? Yes No

What kind of grades did you receive in school? _____

How did you get along with your peers? _____

How did you get along with your teachers? _____

Did you attend college? Yes No Where? _____

Degree? _____



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Occupational History

Are you currently working? Yes No What is your occupation? _____

What is your current position? _____

Where do you work? _____ How long have you been there? _____

Are you satisfied with your job? Yes No If no, explain: _____

Describe any current job stresses you may be experiencing: _____

How well do you get along with your co-workers? _____

How well do you get along with your supervisors? _____

List your last two jobs and how long you worked there: _____

Relationship History

Are you currently Single Married Divorced Widowed Living Together

How long? _____ What is your sexual orientation? _____

Describe your relationship with your spouse or significant other: _____

List any stresses or problems in your relationship: _____

If married, what is your spouse's occupation? _____

Have you been married before (or in a long-term committed relationship)? Yes No

How many times? _____ How long did these relationships last? _____

Please describe the reason for the break-up or divorce: _____

If you have children, what are their names and ages? _____

Describe any problems you may be experiencing with your children: _____

What is your religious preference? _____

How often do you attend religious services? _____ Where? _____

Any hobbies? _____

Is there any other important information about you that has not been covered, which you feel the therapist should know? _____

*****Please complete the attached symptom checklist*****

Symptom Checklist

Check all that apply. Then circle items that are especially bothersome to you.

Recent Past

1. Please check any of the following which may have been particularly stressful to you:

- Job related stress
- Marital conflict
- Death or loss of loved one
- Move to a new place and losing contact with friends or family
- Conflict with children
- Children with behavior problems
- Conflict with parents or extended family
- Feeling stress due to recalling memories of trauma or stress in my life
- Family member with an alcohol or drug problem
- Being abused by someone
- Financial pressure

2. Any of the following symptoms for most of the day, nearly every day, for periods longer than several days at a time:

- Depressed or sad mood
- Loss of interest or pleasure in things I'm normally interested in
- Difficulty falling asleep
- Difficulty staying asleep or waking up too early
- (Average number of hours you are sleeping per night? _____)
- Sleeping too much
- Increased appetite/weight gain (lbs. _____)
- Decreased appetite/weight loss (lbs. _____)
- Fatigue/Poor energy level
- Decreased activity (work, social, physical, sexual)
- Poor concentration or slowed thinking
- Thoughts of suicide
- Excessive feelings of guilt or worthlessness
- Decreased sex drive or interest

3. Any of the following symptoms, more days than not, for months at a time:

- Excessive anxiety or worry for no good reason
- Trembling, twitching or feeling "shaky"
- Muscle tension or muscle aches

Recent Past

- Easily fatigued
- Dry mouth
- Dizziness or lightheadedness
- Nausea, diarrhea or other stomach problems
- Frequent urination
- Feeling keyed up or on edge
- Irritability
- Trouble falling or staying asleep

4. Panic attacks (any period of extreme, increased anxiety lasting from a few minutes up to several hours) with any of the following symptoms:

- Panic attacks/anxiety attacks
- Persistent worry that I will have a panic attack
- Heart pounding or racing heart
- Trembling or shaking
- Sweating
- Choking
- Nausea or stomach problems
- Feelings of unreality
- Numbness or tingling sensations
- Feeling of smothering or shortness of breathe
- Fear of dying
- Fear of going crazy or doing something uncontrolled
- Chest pain or discomfort
- Dizziness, unsteady feelings or faintness
- Flushes, hot flashes or chills
- Avoiding situations or places that may cause panic or severe anxiety

5. Any of the following symptoms for most of the day, nearly every day, for more than four days at a time:

- Euphoric or "high" mood
- Irritable mood
- Decreased need for sleep without feeling tired
- Increased energy level
- Increased activity (work, social, physical, sexual)
- Thoughts speeded up or racing thoughts

Recent Past

- Increased talkativeness or being much more socially outgoing
- Making decisions too impulsively
- Going on spending sprees

6. Check any of the following relating to your alcohol or drug use:

- I've felt alcohol or drugs were causing a problem for me
- I have felt guilty about my use
- Others have annoyed me about my use
- I have had a desire (or made unsuccessful efforts) to cut down or control my use
- I've tried unsuccessfully to control my use
- I've used alcohol or drugs more often or in larger amounts than I intended
- I've had to increase my use of alcohol or drugs to get the desired effect
- I've had problems with withdrawal (shakes, nervousness, insomnia, etc.) when
- I've cut down or stopped using alcohol or drugs
- I've been to a meeting of Alcoholics Anonymous or Narcotics Anonymous

7. Any of the following disturbances in eating or maintaining normal weight:

- Insistence on maintaining body weight below expected for age and height
- Intense fear of gaining weight or becoming fat even though underweight
- I feel "fat" even when others see me as underweight
- Eating binges
- Feeling of lack of control of eating during eating binges
- Vomiting or using laxatives to prevent weight gain
- Being over-concerned about body weight and shape

8. Check any of the following that apply:

- I tend to do things on impulse which end up being damaging to me or others
- I have mood swings (depression, irritability, anger) lasting up to several hours
- I have tried to commit suicide
- I have made cuts, burns or other injuries to myself without wanting to kill myself
- My relationships always seem to work out wrong
- My mood often shifts from being either overconfident to having low self esteem
- I have a hard time sympathizing with other's pain
- I often feel others do not understand me
- I tend to get very hurt or angry when I am criticized or rejected by someone



Recent Past

- I tend to need a lot of reassurance or approval from others
- I am very concerned about my appearance
- Others often expect too much of me

9. Any of the following at any time:

- Hearing voices that sound real even though they are not actually there
- Vivid voices in my head that do not seem like my ideas
- Feeling that others might be putting thoughts in my head
- Feeling others might be able to read my thoughts
- Others feel I am too suspicious or paranoid
- Feeling others might be talking about me

10. Any of the following problems relating to a past severe trauma or stress:

- I have had an experience that was so traumatic that nearly anyone would have been seriously stressed by it
- History of relatives hurting me physically or touching me in sexual areas
- History of unwanted sexual contact
- I have memories or dreams of a stressful event that I have trouble putting out of my head
- I sometimes have flashbacks of past events; or I act or feel as though I am re-living a stressful event from the past
- I try to avoid situations or people that remind me of a stressful event in the past

11. Any of the following obsessions or compulsions:

- Excessive doubting; or repeated, forced unreasonable thoughts, images, or sounds that I cannot get out of my mind
- Urges to check things, wash things, or count repeatedly
- Excessive concern about coming into contact with germs or dirt
- Excessive concern with right/wrong or morality
- Excessive need for things to be exact or symmetrical

Thank you!