Adult Life History Questionnaire

The function of this questionnaire is to give me an initial idea of who you are, what your life has been like, and what your life is like now. All information contained on this form is confidential.

Instructions: Please complete as much of this form as possible.

Section 1: General Information

Name: _____ Date: (mm/dd/yyyy) _____

Address: _____ Date of Birth: (mm/dd/yyyy) _____

_____ Age: _____ Gender: _____

Home phone: (____) _____ Work phone: (____) _____

Relationship/Marital status: _____ Ethnic Background: _____

Emergency contact person: _____ Relationship: _____

Emergency phone: (____) _____

Were you referred to the PTCC ____ yes ____ no. If yes, by who? _____

Referral address: _____ Referral phone: (____) _____

_____ Referral fax: (____) _____

Section 2: Current Concerns

Please explain your main reason for contacting the PTCC: _____

_____

_____

How long have you been troubled by the above? _____

Please indicate how frequently you are typically troubled by the above-mentioned concern.

___constantly ___several times a day ___once a day

___several times a week ___once a week ___a few times a month

___once a month ___once every few months ___once a year

Briefly explain what you have tried in the past to deal with these issues and the results you have had: _____

_____

_____

_____

How has this difficulty interfered with your functioning in the past? _____

_____

_____

Section 3: Family History

	Name	Date of Birth	If deceased, Date of death	Occupation	Level of Education
Father:	_____	_____	_____	_____	_____
Mother:	_____	_____	_____	_____	_____

Where your parents: ___legally married ___never legally married ___separated ___divorced

Were you raised by your parents? ___yes ___no

Were you adopted? ___yes ___no If yes, at what age? _____

Please list the ages of your siblings: _____

Please check the following items that best describe your childhood:

___Happy ___Sad ___Loving ___Painful ___Confusing ___Exciting

___Boring ___Lonely ___Can't remember much ___Other_____

Overall impression of family life as a child:_____

_____

Marital Status: ___Married ___Divorced ___Single ___Engaged ___Separated ___Widowed

If married, number of years:_____ If engaged, length of engagement:_____

How would you rate your relationship with your current spouse or mate? __Never get along __Rarely get along __Sometimes get along __Usually get along __Always get along

Please list the ages of your children: _____

Overall impressions of your current family life: _____

_____

Has any famly member ever been treated for emotional or substance abuse problems, or was any family member ever suspected of having emotional or substance abuse problems?

___Yes ___No. If yes, who? _____ For what reason? _____

_____

Do you have a regular physician? ___Yes ___No If yes, name: _____

Phone: (____)_____ Address: _____

Fax: (____)_____ _____

Date of last physical examination: _____ Reason: _____

Results: _____

Date you were last treated by a physician: _____Reason: _____

Results: _____

I would rate my current physical health as:___Poor ___Fair ___Average ___Good ___Excellent

Present and Past Health Problems:

___Heart	___High Blood Pressure	___Head Injury	___Headaches
___Lung Disease	___Diabetes	___Kidney	___Back Pain
___Stomach	___Bowel/Colitis	___Cancer	___Hormonal
___Thyroid	___Seizures	___Genital/Reproductive	___Allergies

___Other _____

Please list all surgeries and approximate dates: _____

_____

Has anyone in your immediate family had:

___Heart problems ___Suicide ___Alcoholism ___Diabetes ___Disability_____

How many doctor appointments have you had in the last month, total? _____

List how often you take all current prescription and non-prescription medications:

Medicine Name	**Taken for**	**Dosage**	**Number per day prescribed**	**Number per day taken in the past week** (if different)

Section 4: Mental Health History

Have you ever received psychological or psychiatric help in the past? ___Yes ___No

If yes:

Facility/Clinic Name	**Date**	**Treated for**

Have you ever been treated in a hospital for a psychology related condition? ___Yes ___No

If yes, where were you treated? _____

When were you treated? _____ And what were you treated for? _____

_____

Section 5: Military History

Did you ever serve in the U.S. Military? ___Yes ___No If yes, what branch? _____

Date entered: _____ Date Discharged: _____ Type of Discharge: _____

Did you serve in a combat zone while in the military? ___Yes ___No. If yes, where did you serve? _____

Section 6: Educational History

Are you currently attending school? ___Yes ___No. If so, where? _____

What are you studying/major field of study: _____

Most recent previous education including Vocational training

Name of School	**Major/Curriculum**	**Attendance Dates**	**Degree Earned**

Section 7: Vocational/Employment History

Are you presently employed? ___Yes ___No If No, date you last worked: _____

Employer: _____ For How long: _____

Occupation: _____ Hours per week: _____

Employment status: (Check all that apply)

___Social Security Disability ___Disability Retirement ___Sick leave

___Retired ___Worker's Compensation ___Homemaker

___Student ___No job ___Auto Insurance lost wages

___Work First Program ___Other disability insurance ___Other_____

What are your work restrictions (if any): _____

Are there any conflicts at work regarding your problem? ___No ___Minor ___Severe

Have you applied for Social Security Disability? ___Yes ___No

Level of job satisfaction: __Very Good __Good __Average __Below Average __Bad __Very Bad

Rate your relationships with:

Co-workers: __Very Good __Good __Average __Below Average __Bad __Very Bad

Supervisors: __Very Good __Good __Average __Below Average __Bad __Very Bad

Section 8: Legal History

Do you have any current or past involvement with the court system? ___Yes ___No

If yes, please explain: _____

_____

Section 9: Substance Use/Abuse History

How many alcohol drinks did you have in the last week? _____

Do you smoke? ___Yes ___No If yes, number of cigarettes/cigars/pipes smoked per day: _____

Number of years you have smoked, in total (now and in the past): _____

Number of cups of coffee/tea/caffeinated drinks you have per day: _____

Do you use alcohol? ___Yes ___No If yes, when did you last drink? _____

How much did you drink at that time? _____ What did you drink? _____

Type of beverage preferred: Beer_____ Wine_____ Liquor_____

Briefly describe your drinking history: _____

_____

Do you use drugs? ___Yes ___No If yes, time of last use? _____ Type_____

Amount taken_____ How long have you used this drug(s) _____

Type of drug(s) preferred: _____

_____

Do you use alcohol and other drugs in combination? ___Yes ___No

Have you ever been treated for drug and or alcohol problems? ___Yes ___No If yes, when? _____

_____

If yes, where? _____

What were the results of treatment? _____

Section 10: Additional Concerns*

Directions: Please mark only those items that are concerns for you, using a 1, 2, 3, or 4:

1 - mild concern 2 - serious 3 - severe 4 - very severe concern

Leave items blank if they are not concerns for you.

___Swelling
___Sweating
___Light headed or dizzy
___Loss of weight
___Gain of weight
___Other family problems
___Conflict with others
___Work/school problems
___Angry
___Too inactive
___Physically restricted
___Medicine side affects
___Hearing problems
___Heart Palpitations
___Nightmares
___Losing control
___Irritable
___Quick mood changes
___Restless
___Feel detached or dazed
___Troublesome Habits

___Feel Worthless
___Too much alcohol
___Dwell on problems
___Too many fears
___Feel guilty
___Hot or cold spells
___Eating problems
___Tired or drowsy
___Muscle Tightness
___Worry about health
___Other worries
___Nervous
___Feel used
___Panicky
___Headaches
___Other pain
___Excess energy
___Poor sleep
___Poor concentration
___Muscle Weakness
___Shaky or Trembling

___Memory problems
___Feel Confused
___Sexual concerns
___Low energy
___Loss of appetite
___Too many drugs
___Draw away from people
___Negative about future
___Depressed
___Vision problems
___Stiffness
___Bowel problems
___Odd skin sensations
___Stomach Problems
___Hard to trust anyone
___Watched or talked about
___Think about suicide
___Financial stress
___Troubled by the past
___Other health problems
___Other problems

Any additional comments? _____

_____

_____

Client Signature (of person completing this form): _____

Date: _____