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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? ___ yes ___ no. If yes, by who? _____
Referral address: _____ Referral phone: (____) _____
_____ Referral fax: (____) _____

Section 2: Current Concerns

Please explain your main reason for seeking services: _____

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 family 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/cafeinated 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 | ___Feel Worthless | ___Memory problems |
| ___Sweating | ___Too much alcohol | ___Feel Confused |
| ___Light headed or dizzy | ___Dwell on problems | ___Sexual concerns |
| ___Loss of weight | ___Too many fears | ___Low energy |
| ___Gain of weight | ___Feel guilty | ___Loss of appetite |
| ___Other family problems | ___Hot or cold spells | ___Too many drugs |
| ___Conflict with others | ___Eating problems | ___Draw away from people |
| ___Work/school problems | ___Tired or drowsy | ___Negative about future |
| ___Angry | ___Muscle Tightness | ___Depressed |
| ___Too inactive | ___Worry about health | ___Vision problems |
| ___Physically restricted | ___Other worries | ___Stiffness |
| ___Medicine side affects | ___Nervous | ___Bowel problems |
| ___Hearing problems | ___Feel used | ___Odd skin sensations |
| ___Heart Palpitations | ___Panicky | ___Stomach Problems |
| ___Nightmares | ___Headaches | ___Hard to trust anyone |
| ___Losing control | ___Other pain | ___Watched or talked about |
| ___Irritable | ___Excess energy | ___Think about suicide |
| ___Quick mood changes | ___Poor sleep | ___Financial stress |
| ___Restless | ___Poor concentration | ___Troubled by the past |
| ___Feel detached or dazed | ___Muscle Weakness | ___Other health problems |
| ___Troublesome Habits | ___Shaky or Trembling | ___Other problems |

(***HCQ-3:** Copyright 2001, Richard Spoth, PhD, & David Dush, PhD, 3625-555 W Wackerly, Midland, MI, 48642)

Any additional comments? _____

Client Signature (of person completing this form): _____

Date: _____