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Psychologist
Board Certified in Clinical Psychology

Adult Questionnaire

Patient
Name:_____Date:_____

Street Address:_____City, State:_____

Zip Code:_____Home Phone:_____Work Phone:_____

Cell Phone:_____ Best Number to reach you:_____

Date of Birth:_____Age:_____Sex:_____

Marital Status: _____

Current Employer:_____

Name of Spouse/Significant Other:_____Age:_____

Employment Name of Spouse/Significant Other:_____

Work Phone of Spouse/Significant Other:_____

Name of Emergency Contact Person:_____Phone:_____

Current
Difficulty(ies):_____
_____

Who Referred You to Dr. Jenne?:_____Phone:_____

Medical History
Please List Any Current (C) and Past (P) Medical
Problems:_____
_____
_____

Date of Last Physical:_____Physician Name & Number_____

Do you have a history of head injury?_____Date_____

Have you ever lost consciousness?_____Date_____

Have you ever been exposed to toxic substances?_____Date_____Type_____

Do you have hearing or vision problems?_____Corrective device_____

What was the date of your last vision exam_____hearing exam_____?

Do you have any known drug or food allergies?_____

Please List Any Current Medications you are now taking:

Name of Drug	Dose	Times per day	Prescribing MD	Began

Name other medications you have taken in the past:_____

How many times have you been hospitalized overnight in a medical hospital?_____

Describe reason(s) for above:_____

What medical conditions run in your biological family?_____

<u>Mental Health History</u>

Approximately how many hours of sleep you obtain per night:_____

Do you have difficulty falling asleep, remaining asleep, becoming restless, or having nightmares (please describe):_____

Approximately how many meals do you eat per day?_____

Do you have difficulty with your appetite? If so, how?_____

Have you experienced a weight change of 10 lbs. or more per month over the past year?_____

Do you have difficulty with socializing with others? If yes, please describe:_____

Do you have alcohol or drug related problems (including tobacco and caffeine)? If yes, please describe:_____

Please circle all of the following that apply to you and fill in the number of times of each occurrence:

Service	Dates	Provider Name
Previous counseling		
Previous psychological evaluation		
Inpatient psychiatric hospitalization		
Partial hospitalization		
Inpatient alcohol treatment		
Alcohol detoxification		
AA meetings		
Inpatient drug treatment		
Drug detoxification		
NA meetings		
Other support group (list)		

Please describe any mental health conditions for which you have been treated and treatment dates:_____

Are you currently under the treatment of a psychiatrist?_____Name/Phone/Fax of MD:_____

Please list all family members with mental health or psychological problems:_____

Psychosocial History

Marital status (please circle): Single Married Remarried Divorced Widower/Widowed Separated

Number of times married:_____Number of years per marriage_____

Number/Names of children:_____

Would you rate your relationship with your biological parents as good, neutral, or poor?_____

Would you rate your relationship with your siblings (if any) as good, neutral, or poor?_____

Would you rate your relationship with your spouse/significant other as good, neutral, or poor?_____

Would you rate your relationship with your children (if any) as good, neutral, or poor?_____

Circle the response that best reflects you:

Region from: Northeast Country from: USA Other:_____
South
Midwest
West

Raised: Urban
Rural

Religion, if any, in which you were raised:_____Active now?_____

What are your relevant cultural values?_____

Developmental History
Ethnic background:_____

List any complications with your birth:_____

Did you have any difficulties in developmental areas such as walking, talking, and toilet training?_____

Please list any major childhood illnesses you suffered:_____

Employment History
Please list current and previous jobs and state how long you were employed at each:
1._____
2._____
3._____
4._____

Are you satisfied with your current employment, if any?_____

Education History
Circle all that apply to you: High School Diploma GED Some college AA Degree
Bachelors Degree Master's Degree Doctoral Degree

Total number of years in school:_____

Average grade made during school:_____

Did you ever repeat a grade in school?_____What grade(s)?_____

Were you ever diagnosed with a learning disability in school?_____Area:_____

List subjects that were difficult for you:_____

Did you attend special education classes?_____List:_____

#School detentions:_____#School suspensions_____#School expulsions_____

General History
Have you ever been arrested?_____# of times:_____

Do you have any current legal involvement?_____

Do you have a license to drive a car?_____Any DUI's?_____

What are your leisure time activities?_____

What are your chores at home?_____

_____
Patient Signature