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ADULT QUESTIONNAIRE

This questionnaire asks you to respond to a series of questions. This type of background information helps us understand your history and ways we can help you. Please complete as best you can. When appropriate, it also will be helpful for you to bring copies of any previous educational, medical, or psychological reports.

Your Name: _____

REASON FOR REFERRAL

Describe your main reasons for seeking services at this time:

_____

_____

_____

_____

_____

What would you like to change or improve by coming to FamilyFirst?

_____

_____

HOME LIFE

Currently, do you have a: ◯ Spouse ◯ Partner ◯ Significant Other

What is your sexual orientation?: ◯ Heterosexual ◯ Homosexual/Gay

◯ Bisexual ◯ Asexual ◯ Other: _____ ◯ Prefer not to disclose

Who lives at home with you? _____

_____

Do you have any children? ◯ Yes ◯ No

If *Yes*, how many and how old? _____

Describe any current or previous family stressors that might be affecting you at the current time: _____

_____

SOCIAL LIFE

About how many close friends do you have? _____

Compared to others, how do you get along with other people?

◯ Below Average ◯ Average ◯ Above Average

Do you participate in any regular social activities or social organizations?

◯ Yes ◯ No If *Yes,* please describe:_____

_____

What do you enjoy doing (e.g., hobbies, recreational activities, etc.)?_____

_____

What do you consider your strengths or best qualities? _____

_____

OCCUPATIONAL/EDUCATIONAL HISTORY

Current Occupation/Place of Work: _____

Work Status: ◯ Full-time ◯ Part-time ◯ Unemployed ◯ Retired ◯ Other: _____

Please describe your level of satisfaction with your current occupation (e.g., demands, colleagues, relationship with boss, financial, etc.)? _____

_____

Highest Level of Education: _____

If currently a student, name of College/University: _____

Please describe your educational history (any learning disabilities, strengths or weaknesses in school, quality of your performance, other academic struggles, parent or teacher concerns, etc.):

_____

_____

_____

MEDICAL HISTORY

Please list all current medical concerns, conditions, chronic illnesses, and/or allergies:

_____

_____

_____

Date of most recent physical exam: _____

Primary Care Physician: _____

Are you on any medication at this time? ◯ Yes ◯ No

If *Yes,* please provide the name of medication(s), dosage, and prescriber:

_____

_____

Do you have any problems with sleep (trouble falling asleep, staying asleep, waking)?

◯ Yes ◯ No If *Yes,* please describe: _____

Do you have any unusual eating patterns or habits? ◯ Yes ◯ No

If *Yes,* please describe: _____

Do you have any vision or hearing problems?: ◯ Yes ◯ No

If *Yes,* please describe: _____

Do you smoke, vape, chew tobacco, etc.? ◯ Yes ◯ No

If *Yes*, please describe: _____

How often do you consume alcohol (if applicable, how many drinks per week and/or month)?

_____

Do you use (or have you in the past) any type of non-prescription, mood-altering drugs?

◯ Yes ◯ No If *Yes*, what substance, frequency, etc.? _____

_____

Do you (or someone else) believe that you have a problem with alcohol and/or drugs?

◯ Yes ◯ No If *Yes,* please describe: _____

MENTAL HEALTH HISTORY

Have you ever been diagnosed with any behavioral, educational, psychiatric, or substance abuse disorder, such as Attention Deficit/Hyperactivity Disorder (ADHD), Learning Disorder (LD), Anxiety, or Depression?

◯ Yes ◯ No If *Yes,* please describe:_____

_____

_____

As far as you know, has anyone in your family (i.e., parents, siblings, extended family members) experienced any of the above difficulties and/or any other significant mental health problems?

◯ Yes ◯ No If *Yes,* please describe:_____

_____

Have you had any previous counseling/therapy, psychiatric treatment, and/or mental health-related hospitalizations? ◯ Yes ◯ No

If *Yes,* please describe (including when, where, with whom):_____

_____

_____

Have you experienced any significant traumatic events (e.g., abuse, losses, accidents, etc.)?

◯ Yes ◯ No If *Yes,* please describe:_____

_____

How concerned are you about the following issues? Please check your rating below from 1 (*not at all*) to 5 (*extremely*).

Sadness	◯	1	◯	2	◯	3	◯	4	◯ 5
Irritability	◯	1	◯	2	◯	3	◯	4	◯ 5
Worry	◯	1	◯	2	◯	3	◯	4	◯ 5
Anger	◯	1	◯	2	◯	3	◯	4	◯ 5
Aggression	◯	1	◯	2	◯	3	◯	4	◯ 5

Please explain any ratings of 3 and above:_____

_____

Is there any other information that you think may help us in understanding and working with you? _____

_____

_____

_____

_____

_____