Authenticity Counseling
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# ADULT HISTORY QUESTIONNAIRE

Please email or mail this completed form before your initial appointment.

| Client's Name: | Gender: | Birth Date: | Age: |
|---|---|---|---|
| Form Competed by (if other than client): | | E-mail: | |
| Today's Date: | Home Phone: | | |
| Address: | Cell Phone: | | |
| City: | State: | Zip: | |
| Primary Care Provider (PCP): | | PCP Clinic: | |
| PCP Phone: | | | |
| Who Referred You? | | | |

May we leave a message on your? ☐ home phone ☐ cell phone
May we send mail to your home? ☐ yes ☐ no
May we e-mail you? ☐ yes ☐ no
*please note that email is not considered to be a confidential medium of communication

Emergency Contact: _____ Phone Number: _____

What are the concerns that brought you here? _____
_____
_____
_____

**Are you currently experiencing struggles with:**

☐ Anger
☐ Appetite
☐ Anxiety / Worry
☐ Concentration
☐ Depression / Sadness
☐ Drug / Alcohol Use
☐ Educational Problems
☐ Energy Level
☐ Family Problems
☐ Friendships/Relationships
☐ Homicidal Thoughts
☐ Legal Problems
☐ Occupational Problems
☐ Panic
☐Parenting
☐ Sexual Activity or Identity
☐ Sleep
☐ Suicidal Thoughts
☐ Weight
☐ Health Problems (specify):_____
_____
_____
☐ Other (explain):
_____
_____
_____

Have you been in therapy in the past? ☐Yes ☐No
If so, who did you see, and when? _____

If yes, was the therapy beneficial? _____

Have you ever been prescribed medication for mental health issues? If so, please list:
_____

Are you currently taking any prescription medications for your physical or mental health? If so, please list: _____
_____

Are you currently taking any over-the-counter medications, aspirins, herbs, and/or vitamins? If so, please list: _____
_____

Please list what you eat in a typical day: _____
_____
_____

Have you □ Binged / □ Purged / □ Restricted (Check all that apply.)
When did you start?_____
When did you stop (if you stopped)?_____
Have you ever been diagnosed with an eating disorder? □Yes □No If yes, specify: _____
_____

**Please check behaviors and symptoms that happen more often than you would like.**

| | | |
|---|---|---|
| □ Aggression to animals | □ Elevated mood | □ Lying |
| □ Aggression to people | □ Fatigue | □ Memory problems |
| □ Alcohol / Drug use | □ Friendship problems | □ Mood changes |
| □ Anger | □ Gambling | □ Low motivation |
| □ Antisocial behavior | □ Grades inconsistent / low | □ Nightmares / Night terrors |
| □ Anxiety | □ Guilt | □ Panic attacks |
| □ Arguing | □ Hallucinations | □ Phobias / Fears, of what:_____ |
| □ Avoiding people | □ Headaches / Migraines | □ Sexual addiction |
| □ Caffeine use | □ Heart palpitations | □ Sexual difficulties |
| □ Chest pain | □ Hopelessness | □ Sexual identity confusion |
| □ Compulsions / Obsessions | □ Homicidal thoughts | □ Sick frequently |
| □ Concentration problems | □ Hyperactivity | □ Skipping school / Missing work |
| □ Conflict with_____ | □ Impulsivity | □ Sleeping too much / too little |
| □ Depression | □ Internet addiction | □ Speech problems |
| □ Destruction of property | □ Interrupts frequently | □ Stealing |
| □ Disorientation | □ Irritability | □ Stomach aches |
| □ Disorganized thinking | □ Job loss | □ Suicidal thoughts |
| □ Distractibility | □ Judgment errors | □ Withdrawing |
| □ Dizziness | □ Loneliness | □ Work conflict |
| □ Domestic Abuse | □ Loses temper | □ Worrying |
| □ Eating too much / too little / throwing up | | □ Low self esteem |

□ Other (specify): _____

**Which drugs have you used or are you currently using?**

Currently Use:_____ frequency: _____

Past Use: _____ frequency: _____

Have you ever received a drinking ticket? □ Yes □ No If so, when?

Have you ever received a drunk driving ticket? □ Yes □ No If so, when?

Have you ever blacked out from drinking? □ Yes □ No If so, when?

Have you ever been treated for alcohol/drug abuse? □ Yes □ No If so, when?

Has your alcohol/drug use ever caused conflict with family/friends? □ Yes □ No

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**Have you ever attempted suicide/planned to hurt yourself?** □Yes □No

If yes, when: _____

**Are you currently suicidal or have thoughts of self-harm?** □Yes □No

**Have you ever engaged in self-mutilation?** □Yes □No

If yes, when: _____

**Do you currently have plans to harm someone else?** □Yes □No

If yes, when, how, and who? _____

**Have you ever been hospitalized for psychiatric problems?**

If yes, when? _____

Reason?_____

**Have you ever been hospitalized for medical problems?**

If yes, when? _____

Reason?_____

**How would you rate your current physical health?** (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

**How would you rate your current sleeping habits?** (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

**How many times per week do you generally exercise?**_____

**What type of exercise to participate in?** _____

**Have you ever been:**

Sexually abused □ Yes □ No If yes, Age / By Whom: _____

Physically abused □ Yes □ No If yes, Age / By Whom: _____

Neglected □ Yes □ No

**Are you having any problems with your family?** □ Yes □ No _____

_____

_____

**Who do you live with?**

| Name | Relationship | Age |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Ethnicity & Religion**

What is your cultural / ethnic background? _____

Do you consider yourself to be spiritual / religious? □ Yes □ No

**Legal**

Do you currently have, or have you ever had, legal problems? □ Yes □ No Date(s): _____

(if yes, please describe.) _____

**Education**

Are you currently a student? □ Yes □ No If yes, where do you attend? _____

**Are you currently employed?**

□ Full time □ Part Time □ Laid off □ Student □ Homemaker □ No

Where do you work:_____ Title:_____ Length of employment:____

What do you typically do for fun / hobbies? _____

_____

How often do you socialize / go out with friends? _____

What do you do?_____

_____

How many hours per day do you spend on Facebook / Twitter / Internet ? _____

How many hours per day do you spend watching TV? _____

How many hours per day do you spend playing video games? _____

How much / often do you text? _____

How many hours per night do you sleep? _____

What time do you go to bed? _____Wake up? _____Do you have a regular routine? □Yes □No

Do you wake up in the middle of the night to text or answer texts? □Yes □No

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Are you having any difficulties in your current romantic relationship? □ Yes □ No

If yes, what are they? _____

_____

Are you: □ Heterosexual □ Homosexual □ Bisexual □ Unsure

Marital Status: □ Single, never married □ Domestic Partnership □ Married □ Separated

□ Divorced □ Widowed

What do you wish to accomplish in the initial session? _____
_____

What are your goals for therapy? _____
_____
_____

What else would be helpful to know that would help with your treatment? _____
_____
_____

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