Confidential Adult Questionnaire ***Cathy Leslie, Ph.D., PLLC***

Client Name: _____ Date: _____

Please complete this form to help your clinician as he/she talks with you regarding your problems. If you are unsure about the answers to any of these questions, please discuss them with your clinician.

What is the primary reason you are seeking help at this time? _____
_____
_____

Please check all of the following problems/symptoms which apply to you.

[ ] Panicky feelings
[ ] Nervousness
[ ] Anxiety
[ ] Fears
[ ] Phobic Avoidance
[ ] Procrastination
[ ] Nervous tics
[ ] Driven to perform certain behaviors
[ ] Headaches
[ ] Chest pains
[ ] Rapid heartbeat
[ ] Dizziness
[ ] Excessive sweating
[ ] Appetite problem
[ ] Weight loss/gain
[ ] Bowel/stomach trouble
[ ] Bingeing
[ ] Vomiting
[ ] Purging
[ ] Muscle tension
[ ] Pain
[ ] Hearing problems
[ ] Menstrual Problems
[ ] Sexual problems
[ ] Drug/alcohol abuse
[ ] Depression
[ ] Unhappiness
[ ] Seasonal variations in mood
[ ] Tearfulness
[ ] Loss of interest
[ ] Sleep Problems
[ ] Nightmares

[ ] No sense of purpose
[ ] Shyness
[ ] Loneliness
[ ] Relationship problems
[ ] Job problems
[ ] Educational problems
[ ] Financial problems
[ ] Career issues
[ ] Boredom
[ ] Temper outbursts
[ ] Anger problems
[ ] Loss of control
[ ] Suspicious of others
[ ] Hearing unidentified voices or sounds
[ ] Guilt
[ ] Jealousy
[ ] Difficulty making decisions
[ ] Homicidal thoughts
[ ] Suicidal thoughts
[ ] History of abuse
[ ] Flash backs
[ ] Time loss
[ ] Feeling out of body
[ ] Feeling unreal
[ ] Smelling unidentified odors
[ ] Sensitivity to noise or lights
[ ] Racing thoughts
[ ] Withdrawal
[ ] Reduced Concentration
[ ] Memory Problems
[ ] Low self-esteem
[ ] Fatigue

Mental Health

Is there a family history of (check all that apply):

□ Depression □ Anxiety □ Suicide □ Bipolar Disorder□ Psychosis □ Alcoholism □ Substance Abuse

If yes, please describe the relationship to you and the problem:

Concern_____ Which relatives_____

Concern_____ Which relatives_____

Concern_____ Which relatives_____

Have you attempted suicide? □ No □ Yes

Do you currently have suicidal thoughts? □ No □ Yes

Do you ever feel angry enough at home, work, or school to do something you might regret?

□ No □Yes

Childhood History

As a child did you have any problems with: **Age**

□Learning disabilities □ No □ Yes _____

□Hyperactivity □ No □ Yes _____

□School fears □ No □ Yes _____

□Depression □ No □ Yes _____

□Sexual or physical abuse □ No □ Yes _____

Did you have any other major childhood (0-17 years) school, learning, or emotional problems?

□ No □ Yes If so, please describe: _____

Family History

Which of the following best describes the family in which you grew up?

Warm and Accepting			Average			Distant, Hostile and Fighting		
1	2	3	4	5	6	7	8	9

Was the family/home disrupted by serious illness/accident/death/separation/divorce?

□ No □ Yes If yes, please describe _____

_____

Previous Counseling or Chemical Dependency Services:

Have you ever seen anyone or are you currently seeing anyone for:

Individual Therapy □ No □ Yes Marital/Couples Therapy □ No □ Yes

Group Psychotherapy □ No □ Yes Sex Therapy □ No □ Yes.

Facility/Counselor Name	Month/Year Seen	Reason Seen	Helpful?
_____	_____	_____	□ No □ Yes
_____	_____	_____	□ No □ Yes
_____	_____	_____	□ No □ Yes

Have you experienced any unusually severe stresses during the past year? Yes No

If yes, please describe:

_____

_____

Job Satisfaction*:* □ Very Satisfied □ Fairly Satisfied □ Not At All Satisfied

Have you ever taken work leave for mental health/chemical dependency problems?

□ No □ Yes How Long? _____

What is your job/profession? _____

Medical/Lifestyle History

Current health □ Poor □ Fair □ Good □ Excellent

Do you have any medical problems or diseases?

_____

_____

Did you ever have a head injury? □ No □ Yes

Did you ever have seizures? □ No □ Yes

Medication(s) currently used:

Medication/Dose	Date Prescribed	Why Prescribed	Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you take any herbal medications? □ No □ Yes, please name _____

Past Hospitalizations (Psychiatric/Chemical Dependency)

Date(s)	Reasons	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

Alcohol Use

How often do you use alcohol? □ None □ Monthly □ Weekly □ Daily

On the days that you drink, how many drinks do you usually have?

□ Less than 2 □ 2-5 □ 5 or more

Do you consider it a problem? □ No □ Yes; Do others consider it a problem? □ No □ Yes

Do you have problems at work/school because of drinking or drug use? □ No □ Yes

Have you had problems with alcohol in the past? □ No □ Yes

Nicotine use

Do you smoke or use tobacco now? □ No □ Yes, how much per day? _____

Have you smoked or used tobacco in the past? □ No □ Yes

Caffeine

How many cups of caffeinated coffee/tea do you drink a day?_____

How many caffeinated soft drinks?_____

Drug use

Marijuana: □ None □ Occasionally □ Daily □ Weekly

Do you use other non-prescription substances? □ No □ Yes, what substances?_____

Do you take prescription substances more than prescribed? □ No □ Yes

Legal History: □ None □ Litigation □ Arrest □ Victimization, specify _____

Are you currently involved in a court case? □ No □ Yes, which type? _____