Family Counseling Center
Adult Questionnaire

Please complete the following and bring it with you to your first session. If there are areas or questions you are unsure of, ask your therapist when you come in.

Date: _____ Name: _____ DOB: _____

1. What problem areas promoted you to seek treatment here?

_____

_____

_____

2. If these problems have affected any of the following areas of your life, please describe:

Family relationships: _____

_____

Social relationships: _____

_____

Completion of daily responsibilities, tasks, or chores: _____

_____

_____

3. How were you referred to this Center? _____

4. Treatment History (begin with most recent)

Type: A – Psychiatric inpatient
B – Other professional help (counselor, clergy, social worker, psychologist, other)
C – Chemical Dependency Treatment

Type (See Above)	Dates	Individual Or Facility & Location	Length Of Stay, Number Of Sessions

5. Benefits from previous therapy experiences: _____

_____

_____

Mental Health Issues:

Have you recently or do you currently experience the following?

Yes	No		Yes	No	
___	___	Suicidal thoughts	___	___	Difficulty eating
___	___	Suicide plans	___	___	Depression, loneliness, or hopelessness
___	___	Suicide attempts and/or self-inflicted injury	___	___	Crying often
			___	___	Frightening dreams or thoughts
___	___	A tendency to be shy or sensitive	___	___	A strong dislike of criticism
___	___	Often annoyed by little things	___	___	Difficulty completing tasks
___	___	A frequent loss of temper	___	___	Violent or destructive behavior
___	___	Difficulty expressing feelings	___	___	Difficulty remembering
___	___	Nervousness, anxiety or worry	___	___	Difficulty concentrating
___	___	Difficulty relaxing	___	___	Mental Confusion
___	___	Difficulty making decisions	___	___	Homicidal thoughts
___	___	Difficulty sleeping	___	___	Losing track of time

Medical History:

1. Do you have any medical problems? _____

_____

2. Do you have a past history of any serious medical problems, illnesses, or injuries? _____

_____

3. Do you smoke? ___Yes ___No How much? _____

4. Do you take over-the-counter medications? ___Yes ___No Describe: _____

_____

5. Do you take prescription medications? ___Yes ___No

Medication Name	Dose	Taken How Often	Taken As Prescribed?

Family/Relationship History:

1. Father's name: _____ Age: _____ (___deceased)
   Previous/current occupation: _____
2. Mother's name: _____ Age: _____(__deceased)
   Previous/current occupation: _____
3. Please note any biological relatives you feel may have had a mental health or alcohol/drug problem (parents, siblings, grandparents, uncles, aunts, etc.): _____

_____

_____

4. Are your parents living together? ___Yes ___No ___Divorced ___Separated __Deceased

5. How many brothers and sisters do you have? _____

6. Current relationship status: ___Married ___Widowed ___Single ___Engaged ___Divorced ___Separated ___Other long-term
   If you are married or have a significant other, what is his/her name? _____
   How long have you been married or with your significant other? _____
   If you are/have been married, how many marriages have you had? _____

7. Children's names:	Age	Live with you?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

   Is custody an issue? ___Yes ___No

8. Prior to age 18, were you abused by anyone in your family or by anyone else who was older than you?
   Physically ___Yes ___No At what age? _____
   Sexually ___Yes ___No At what age? _____
   Emotionally (verbal, mental, neglect) ___Yes ___No At what age? _____

9. As a teenager or adult, have you been abused by someone in a dating, marital, or other significant relationship?
   Physically ___Yes ___No
   Sexually ___Yes ___No
   Emotionally (verbal, mental, neglect) ___Yes ___No

10. If you are disabled, have you been abused by a family member or other caregiver?
    Physically ___Yes ___No
    Sexually ___Yes ___No
    Emotionally (verbal, mental, neglect) ___Yes ___No

11. If you are over 65, have you been abused by a family member or caregiver since you turned 65?
    Physically ___Yes ___No
    Sexually ___Yes ___No
    Emotionally (verbal, mental, neglect) ___Yes ___No

Social Relationships:

1. As a child and adolescent, what were you like socially, e.g., shy or outgoing? _____

_____

   Did you make friends easily? ___Yes ___No

2. As an adult, do you make friends easily? ___Yes ___No

3. Are you involved in any organized social activities or groups? ___Yes ___No
   If yes, describe: _____

4. How do you react when you get angry with someone? _____

_____

Religion/Spirituality:

1. What religion were you raised in? _____

2. Do you currently practice this religion? ___Yes ___No

3. Do you currently practice another religion? ___Yes ___No
   If yes, what religion? _____

Education History:

1. Last grade completed: (K-12) _____

2. High school attended: _____

3. College or vocational school attended: _____

4. Degrees or certificates held: _____

5. How would you describe yourself academically in:

   Grade School: _____

   Junior High: _____

   High School: _____

   College/Technical: _____

6. Did you have learning problems in school? ___Yes ___No; Please describe: _____

_____

7. Do you have a diagnosed learning problem? ___Yes ___No ; Please describe: _____

_____

8. Are you satisfied with your present education level? ___Yes ___No

9. Can you read? ___Yes ___No Can you write? ___Yes ___No

Employment History:

1. Occupation: _____

2. Most recent or current employment: _____

3. Name of employer: _____

4. Length of time at current job: _____

5. Usual type of employment: _____

6. How many months out of the last 12 were you employed? _____

7. What are your goals in the area of employment? _____

_____

Alcohol/Drug History:

1. Do you use alcohol? ___Yes ___No

2. Has anyone ever suggested you might have a problem with alcohol? ___Yes ___No

3. Under what circumstances do you use alcohol?

   _____ Amount: _____

   _____ Amount: _____

4. Do you use street drugs? ___Yes ___No

5. Under what circumstances do you use street drugs?

_____ Amount: _____

_____ Amount: _____

6. Yes ___ No ___Have you ever felt you ought to cut down on your drinking or drug use?

7. Yes ___ No ___Have you ever had people annoy you by criticizing your drinking or drug use?

8. Yes ___ No ___ Have you ever felt bad or guilty about your drinking or drug use?

9. Yes ___ No ___ Have you ever had a drink or used drugs as an eye opener first thing in the morning to steady your nerves or get rid of a hangover, or to get the day started?

Legal History:

Date	Type	Outcome	Alcohol/Drug Related?

1. Probation Officer: _____ Phone Number: _____

2. Do you have any legal issues pending? ___Yes ___No If yes, please describe: _____

_____

Military History:

1. Were you in the service? ___Yes ___No If yes, what branch? _____

2. Discharge status: _____

Other:

1. What kinds of things do you do for fun or relaxation? _____

_____

2. What are your personal strengths? _____

_____