ADULT QUESTIONNAIRE

Date ____________________

Full Name __________________________________[ ]Male [ ]Female Birthdate: ___________

Address ____

Street   City   State   Zip

Phones:

Home ______________________ Leave a message w/a person? [ ]Y [ ]N Voicemail? [ ]Y [ ]N

Cell ________________________ Leave a message w/a person? [ ]Y [ ]N Voicemail? [ ]Y [ ]N

Work _______________________ Leave a message w/a person? [ ]Y [ ]N Voicemail? [ ]Y [ ]N

Other _______________________ Leave a message w/a person? [ ]Y [ ]N Voicemail? [ ]Y [ ]N

Email __________________________________

Occupation, Employer____

Emergency Contact Name _______________________________ Phone: __________________

Insurance Company____________________________

Will you be financially responsible for these services? [ ]Y [ ]N If "No," please complete box.

Responsible Party Information

Name _______________________________ Relationship to Client ______________________

DOB: ________________________

Address ____

Home phone _________________________ Other phone ________________________________

Please do not write below this line

FAMILY INFORMATION

Marital Status: [ ]Single [ ]Married [ ]Separated (Date________) [ ]Divorced (Date________)
If Married, Name of Spouse ___________________________________

Do you have any children? [ ]Yes [ ]No
Who has physical custody?______________________ Legal custody?____________________

If you share custody of your children, please describe the current arrangement, including visitation:

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List all people living in your home:

Name	Age	Relationship	Current Health	Comments
________________________	____	__________	Good Fair Poor	__________________________
________________________	____	__________	Good Fair Poor	__________________________
________________________	____	__________	Good Fair Poor	__________________________
________________________	____	__________	Good Fair Poor	__________________________
________________________	____	__________	Good Fair Poor	__________________________
________________________	____	__________	Good Fair Poor	__________________________
________________________	____	__________	Good Fair Poor	__________________________

Your Parents' Marital Status _____________Year of separation/divorce, if applicable________

Has any other member of your immediate family had mental health treatment?
[ ]Yes [ ]No If "Yes," please elaborate: ____

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Please do not write below this line

FAMILY RECORD *Indicate with a check-mark the condition and relationship of any blood relative who has or has had any of the conditions listed below.*	None	Client	Father	Mother	Grandfather	Grandmother	Brother	Sister	Other	Indicate Other Relative
Alcoholism/substance abuse										
Allergies										
Anxiety Disorder										
Attention Problems										
Birth Defects										
Autism/Developmental Disorder										
Depression										
Diabetes										
Eating Disorder										
Learning Disorder										
Major Mental Illness										
Migraines										
Obsessive-Compulsive Dis.										
Seizure Disorder										
Thyroid Problems										
Tic Disorder										
Other										

Other Comments: ____

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Please do not write below this line

HEALTH INFORMATION

Medical Problems: [ ]Yes [ ]No If yes, briefly explain:

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Allergies? [ ]Yes [ ]No If yes, please list:

____

Sleep problems? [ ]Yes [ ]No If yes, briefly explain:

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____

Name of Primary Care Physician: ____________________________________

Last Physical Exam Date and Results:

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____

Are you taking any medications? [ ]Yes [ ]No If yes, please list:

____

Name of Prescribing Doctor: ____________________________________

Have you ever been under the care of another mental health provider? [ ]Y [ ]N If “Yes,” please elaborate:

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Please do no write below this line

Please provide a brief description of the help you are looking for.

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Please do no write below this line