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 Information

Private Insurance company (e.g. BCBS, Cigna, etc)? [ ]Yes [ ]No

Please file on your own according to your out-of-network benefits

Public Insurance company (Medicaid, Medicare)? [ ]Yes [ ]No

If YES, Name of insurance company (list all): _____;

ID(s)# _____ *Date issued:* _____

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 _____

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:

_____

_____

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: _____

_____

_____

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: _____

_____

_____

Please do not write below this line

HEALTH INFORMATION

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

_____

_____

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

_____

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

_____

_____

Name of Primary Care Physician: _____

Last Physical Exam Date and Results:

_____

_____

Are you taking any medications? [ ]Yes [ ]No If yes, please list medications and describe any benefit or adverse effects from those medications:

_____

_____

_____

_____

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