ADULT COUNSELING QUESTIONNAIRE

Providing the following information will help me better understand your questions and concerns. All information will be kept confidential. Thank you for your time and effort in completing this! Write additional comments as needed.

Name:	Sex: ❑ M ❑ F	Age:	Birth Date: / /	Today's Date: / /

Who referred you to us? _____

What led you to seek counseling at this time? _____

What specific concerns would you like addressed? _____

What do you hope to get out of counseling? _____

What do you hope to change? _____

FAMILY HISTORY

Were you raised by your biological parents? ❑ Yes ❑ No If no, please identify who raised you: _____

Did your parents stay together? ❑ Yes ❑ No If no, your age when they split up: _____

Is your mother still living? ❑ Yes ❑ No If no, when did she die? _____

Is your father still living? ❑ Yes ❑ No If no, when did he die? _____

Overall, your parents' marriage was: ❑ Very happy ❑ Happy ❑ Average ❑ Unhappy

Overall, your childhood was: ❑ Very happy ❑ Happy ❑ Average ❑ Unhappy

As a child, you felt closest to: ❑ Your mother ❑ Your father ❑ Another: _____

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Name of Client: _____

Brothers & sisters:	Sex	Degree	Age	Living?	Occupation	Marital Status	Residence
	❑M ❑F	❑Full ❑½ ❑step		❑Yes ❑No		S M D W	❑Local ❑Out of area
	❑M ❑F	❑Full ❑½ ❑step		❑Yes ❑No		S M D W	❑Local ❑Out of area
	❑M ❑F	❑Full ❑½ ❑step		❑Yes ❑No		S M D W	❑Local ❑Out of area
	❑M ❑F	❑Full ❑½ ❑step		❑Yes ❑No		S M D W	❑Local ❑Out of area
	❑M ❑F	❑Full ❑½ ❑step		❑Yes ❑No		S M D W	❑Local ❑Out of area
	❑M ❑F	❑Full ❑½ ❑step		❑Yes ❑No		S M D W	❑Local ❑Out of area

Medical conditions in the family (e.g. heart disease, cancer, diabetes, thyroid problems, etc.): ______________________

____

Mental health conditions in the family (e.g., depression, anxiety, substance abuse, etc.): ______________________

____

MEDICAL HISTORY

How is your current health? ____

____

How many hours per night do you sleep, lately? __________ How long does it take to fall asleep, lately? __________

Do you wake up during the night? ❑ Yes ❑ No If yes, please describe: ______________________________

Recent changes in your weight? ❑ Yes ❑ No If yes, please describe: ______________________________

____

Please list any other significant medical problems, illnesses, injuries, or operations you have had:

____

____

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CURRENT Regular Medicines ***(Prescription, Over the Counter, Herbal)***				
Medicine	Dose	Taking how long?	Taking for:	Benefits or Side Effects?

PRIOR Regular Medicines ***(Prescription, Over the Counter, Herbal)***				
Medicine	Dose	Took how long?	Took for:	Benefits or Side Effects?

Do you have allergies to any medications? ❑ Yes ❑ No If Yes, which one(s)? _____

Your Physician: _____ Phone: _____

CONSULTATION WITH YOUR PHYSICIAN

YES____ NO____ Did your primary physician (PCP) or psychiatrist refer you for treatment?

YES____ NO____ May we consult your PCP and/or psychiatrist? If yes, you will have to sign a separate release.

How much alcohol do you drink per week? ❑ I never drink ❑ 0-1 drinks ❑ 2-4 drinks ❑ 5-10 drinks ❑ 11+

Did you ever drink more heavily? ❑ Yes ❑ No If Yes, describe: _____

How much do you smoke?

❑ Never smoked ❑ Have quit for less than a year ❑ ½ to 1 ppd ❑ More than 2 ppd

❑ Have quit for more than a year ❑ Less than ½ pack per day (ppd) ❑ 1-2 ppd

How much caffeine do you drink, including coffee, tea and soda?

❑ None ❑ 1-2 cups per day (cpd) ❑ 3-4 cpd ❑ 5-6 cpd ❑ 7-10 cpd ❑ 11+ cpd

Have you used:	In past	Amount/Freq	Currently	Amount/Freq
Pot, marijuana, hashish, grass	❑ Yes ❑ No		❑ Yes ❑ No	
Amphetamines, stimulants, uppers, speed	❑ Yes ❑ No		❑ Yes ❑ No	
Barbiturates, sedatives, sleeping pills, Seconal, Quaaludes	❑ Yes ❑ No		❑ Yes ❑ No	

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Tranquilizers, Valium, Librium	❑ Yes ❑ No		❑ Yes ❑ No	
Cocaine, coke, crack	❑ Yes ❑ No		❑ Yes ❑ No	
Heroin	❑ Yes ❑ No		❑ Yes ❑ No	
Non-heroin opiates (morphine, methadone, Darvon, etc.)	❑ Yes ❑ No		❑ Yes ❑ No	
Psychedelics (LSD, mescaline, peyote, DMT, PCP)	❑ Yes ❑ No		❑ Yes ❑ No	
Misused prescription drugs:	❑ Yes ❑ No		❑ Yes ❑ No	
Other (specify):	❑ Yes ❑ No		❑ Yes ❑ No	

MENTAL HEALTH HISTORY

How would you describe your mood most of the time?

❑ Normal and fairly stable ❑ Depressed, sad, or blue ❑ Grouchy or irritable
❑ Anxious or nervous ❑ Labile (mood changes a lot) ❑ Other: _____

Mood	
Have you ever had problems with depression?	❑ Yes ❑ No
Do you feel sad, unhappy, or depressed more than most others your age?	❑ Yes ❑ No
Do you tend to be moody a lot of the time?	❑ Yes ❑ No
Do you often feel down during the winter?	❑ Yes ❑ No
Do you experience periods of super-intense energy that last many hours or days and that you can't shut off?	❑ Yes ❑ No
Have you ever felt as if you might hurt yourself or try to kill yourself?	❑ Yes ❑ No

Anxiety	
Do you worry more than most others your age?	❑ Yes ❑ No
Have you ever had any problems with anxiety?	❑ Yes ❑ No
Ever had a panic attack that made you feel as if you were suddenly suffocating or having a heart attack for no apparent reason?	❑ Yes ❑ No
Are there certain worries that you often can't kick out of your mind, even though they may seem silly to other people?	❑ Yes ❑ No
Do you have certain things you do that aren't necessary and may even seem foolish but you must do or you'll feel too nervous?	❑ Yes ❑ No

Temper	
Do you have problems with your temper?	❑ Yes ❑ No
Do other people complain about your temper?	❑ Yes ❑ No
Have you ever lost your temper enough to hurt anyone or damage any property?	❑ Yes ❑ No
Have you ever lost your job or had legal problems because of your temper?	❑ Yes ❑ No
Have you ever gotten into a physical fight?	❑ Yes ❑ No If Yes, how many? ❑ Once ❑ 2-5 ❑ 6+
Did you ever use a weapon in a fight?	❑ Yes ❑ No

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Outpatient Services (e.g. counselor, psychologist, psychiatrist)			
With whom/where	When	How Long	Results

Psychiatric Hospitalization			
Where	When	How Long	Results

SOCIAL HISTORY

Did you ever run away from home overnight? ❑ Yes ❑ No If Yes, how many times? _____

Have you ever been arrested or in trouble with the law? ❑ Yes ❑ No If Yes, details? _____

Do you have a driver's license? ❑ Yes ❑ No If no, why not? _____

How many car accidents have you ever been in? ❑ 0 ❑ 1 ❑ 2- 3 ❑ 4 or more

What were friendships like as a child? ❑ Great ❑ Pretty Good ❑ Okay ❑ Often frustrating ❑ Terrible

What are friendships like now for you? ❑ Great ❑ Pretty Good ❑ Okay ❑ Often frustrating ❑ Terrible

Do you have a best friend or family member you know you can confide in? ❑ Yes ❑ No

Compared to other households, the level of stress in your home is:
❑ Much lower ❑ Lower ❑ About the same ❑ Higher ❑ Much higher

If *not* married, are you currently in an intimate relationship? ❑ Yes ❑ No If Yes, how long? _____

Have you served in the military? ❑ Yes ❑ No If Yes, details? _____

Have you been exposed to traumatic events? (e.g., abuse, accident, combat, crime, etc.) ❑ Yes ❑ No

Please describe your non-work activities (e.g. church, clubs, sports, music, hobbies)

_____

_____

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MARITAL HISTORY

If never married, check ❑, and skip this section

What is your current marital status? ❑ Married when?________ ❑ Separated when?________ ❑ Divorced when?________ ❑ Widowed when?________

Spouse's Name	Age	Education (in years)	Occupation

Compared to other couples, the level of satisfaction in your relationship is:
❑ Much lower ❑ Lower ❑ About the same ❑ Higher ❑ Much higher

Is your spouse willing, if asked, to come to counseling with you? ❑ Yes ❑ No ❑ Not sure

Have either of you filed for divorce? ❑ Yes ❑ No ❑ Not sure

Have you been married before? ❑ Yes ❑ No

If yes, please complete:

	Dates of marriage		Marriage ended by:		
1st	From:________	To:_______	❑ Death	❑ Annulled	❑ Divorce
2nd	From:________	To:________	❑ Death	❑ Annulled	❑ Divorce
3rd	From:________	To:________	❑ Death	❑ Annulled	❑ Divorce

PARENTING HISTORY

If no children, check ❑, and skip this section

Your children:	Relation	Sex	Age	Living?	Education in years	Marital Status	Residence
	❑bio ❑step ❑adopted	❑M ❑F		❑Yes ❑No		S M D W	❑Home ❑Local ❑Out of area
	❑bio ❑step ❑adopted	❑M ❑F		❑Yes ❑No		S M D W	❑Home ❑Local ❑Out of area
	❑bio ❑step ❑adopted	❑M ❑F		❑Yes ❑No		S M D W	❑Home ❑Local ❑Out of area
	❑bio ❑step ❑adopted	❑M ❑F		❑Yes ❑No		S M D W	❑Home ❑Local ❑Out of area
	❑bio ❑step ❑adopted	❑M ❑F		❑Yes ❑No		S M D W	❑Home ❑Local ❑Out of area
	❑bio ❑step ❑adopted	❑M ❑F		❑Yes ❑No		S M D W	❑Home ❑Local ❑Out of area

How are your relationships with your children? ______________________________________

____

Do you have (or have you had) foster children? ❑ Yes ❑ No If Yes, details: ____________________

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RELIGIOUS HISTORY

How important are spiritual issues in your life? _____

Are there spiritual concerns or questions you would like addressed in counseling? _____

Church you currently attend, if any? _____ Minister: _____

EDUCATIONAL HISTORY

Highest grade or level of schooling you completed: _____

How would you describe your grades in school? ❑ Below Average ❑ Average ❑ Above Average

What was your best subject in school? _____ Worst? _____

Other training? _____

WORK HISTORY

Please briefly describe your work history:

Years at job	Type of work

Please describe what you like and dislike about your work experiences so far:

_____

_____

_____

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MISCELLANEOUS

What do you like about yourself? (e.g. strengths, accomplishments, personal appearance, skills, activities, character qualities, lifestyle, values, etc.)

This form has asked you a lot of questions. Are there any other details you want me to know about?

EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone number: _____

- **I give authorization for Resolute Counseling to contact my emergency contact in the event of an emergency situation: _____ (Initial here)**

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