SOCIAL/MEDICAL QUESTIONNAIRE - ADULTS

Patient _____ Date _____

Date of Birth ____/____/____ Age _____ Sex _____

Briefly, why are you seeking treatment at this time?

_____

_____

Who referred you to our office? _____

If this is a professional who referred you, do you give consent that we may acknowledge to this person/office that we have seen you? ____ Yes ____ No

FAMILY HISTORY

Place of Birth _____ No. of Siblings _____ Your No. In Family _____ Parents' Marital Status Now _____

What is your race? ___ Black ___ White ___ Native American ___Hispanic ___ Asian Other (specify) _____

Father's Education _____ Occupation _____ Age _____ If Deceased, give year _____

Mother's Education _____ Occupation _____ Age _____ If Deceased, give year _____

Did your Father work while you grew up? ___ Yes ___ No Did your Mother work while you grew up? ___ Yes ___ No

While growing up, were your parents: _____ Single _____ Married _____ Separated _____Divorced

If Separated/Divorced, how old were you at the time? _____

With whom did you live while you were growing up? _____

_____

Describe your relationship with your:

Father _____

_____

Mother_____

_____

Siblings (please list name and age of each sibling) _____

_____

If any brother/sister is deceased, give name, cause and age of death _____

_____

Have you ever been physically or sexually abused (circle which one)? ____ No ____ Yes ____ Don't know
If "Yes," when and by whom? _____

Have you ever physically or sexually abused anyone (circle which one)? ____ No ____ Yes
If "Yes," when and who? _____

Have your parents or any other family members had any mental health or alcohol/other drug problems? __ No ___Yes

If "Yes," describe who and what: _____

_____

ADULT/MARITAL HISTORY

Your current marital status: ____ Single ____ Married ____Divorced ____Widowed

____ Separated ____ Unmarried, Living with Significant Other

If female, your maiden name: _____

Your first
marriage _____/_____/_____/_____
Age Date No. of Children If divorced, give date

Your second
marriage _____/_____/_____/_____
Age Date No. of Children If divorced, give date

Any additional marital information: _____

List the names and ages of your children:

Name of Child	Age	With Whom Child Lives	Quality of your Relationship	Problems

With whom do you currently live? Name _____ Relationship _____

Do you consider yourself to be? ____ Heterosexual ____ Homosexual ____ Bi-Sexual _____ Other

Check the best description of your relationship with your present significant other:

____ Excellent ____ Good ____ Fair ____ Poor

Conflicts are over: ___ money ___ mental health problems ___ communication
___ friends ___alcohol/other drug use ___ in-laws
___ job ___ legal problems ___ sex
___ other(s)-describe:_____

Any additional information: _____

EDUCATION

What is the highest
grade you completed? _____Grade ___ G.E.D. ____Some College ____ College Degree ____ Graduate Degree

Last school attended _____

List any specialized vocational training you have: _____

Are you satisfied with your education? ____ Yes ____ No If "no," why not?"_____

VOCATIONAL

Are you currently employed? ____ Yes ____ No If employed, how long in this job? _____

Type of Work _____ Are you satisfied with your job? _____

What jobs have you held in the past?

Job	Length of Time	Reason for Leaving	Job Satisfaction

MILITARY SERVICE

Served in the armed forces? ____ No ____ Yes Years: _____ Branch: _____

Duty _____ Highest Rank _____ Honorable Discharge? ____ Yes ____ No

SOCIAL RELATIONSHIPS

Describe your friendships: __ I have no friends __ I have only acquaintances __ I have both acquaintances and close friends

How many close friends do you have? _____

How often do you see them? ____ Daily ____ Frequently ____ Once in a while ____ Infrequently

LEISURE TIME

How do you spend most of your leisure time? ____ Alone ____ With Others ____ About Equal

List your hobbies, leisure time activities, interests and talents: _____

_____ Which do you like best? _____

What do you and your friends/acquaintances do together? _____

Have your leisure activities changed in the last two years? ____ Yes ____ No

If "Yes," explain how? _____

FINANCES

Do you currently have financial problems? ____ Yes No ____ If "Yes," explain: _____

_____

What have you done to help your financial problems? _____

LEGAL PROBLEMS

Have you ever been involved with the police or the courts? ____ Yes No ____ If "Yes," specify the:

Charge	Date	Outcome	Was this related to alcohol or other drug use?

MEDICAL/HEALTH HISTORY

Describe your general physical health: ____ Good ____ Fair ____ Poor

When was your last physical exam? (month) _____ (year) _____ I can't remember the exact date, but it was approximately _____ years ago.

Reason for last physical exam _____

Name of your physician _____

Address _____

If you were referred to our office by someone other than your Primary Care Physician or you initiated treatment on your own,

do we have your permission to contact your PCP and inform them of your visit/status? _____ Yes _____ No

Check all of the following physical conditions that apply to you now or in the past:

___ Thyroid Problems	___ Headaches	___ Menstrual Problems	___ Low Blood Sugar
___ Diabetes Mellitus	___ Chest Pains	___ High Blood Pressure	___ Trouble Sleeping
___ Seizures	___ Asthma	___ Stomach Ulcers	___ Colitis
___ Attention Problems	___ Other(s) (Specify) _____		

Do you now have or have you in the past had any:

Sleep problems? ____ No ____ Yes If "yes," explain: _____

Describe your sleep generally: ____ Good ____ Fair ____ Poor

Allergies? ____ No ____ Yes If "yes," list them: _____

Have you ever had an allergic reaction to a food, medicine, environmental stimulus (e.g. dust, grass) drug or alcohol? ____ No ____ Yes if "Yes," to what? _____

Contagious or other diseases? ____ No ____ Yes If "yes," which? _____

Accidents/Injuries? ____ No ____ Yes If "Yes," describe? _____

Surgery? ____ No ____ Yes If "Yes," explain? _____

Do you have a Disability/Handicap? ____ No Yes ____ If "Yes," describe: _____

Check those you eat: ____ Meats ____ Fruits and Vegetables ____ Dairy Products ____ Breads

Describe your appetite:____ Good ____ Fair____ Poor ____ Do you eat regularly? ____ Yes No ____

List any illnesses that run in your family: _____

Have you ever had a major illness? ____ No ____ Yes If "Yes," describe the:

Illness Year

_____

_____

_____

Have you ever been hospitalized? ____ No Yes ____ If "Yes," explain the:

Reasons for the Hospitalizations Year

_____

_____

_____

EMOTIONAL HEALTH

Have you ever had previous treatment/evaluation of emotional, learning or school-related problems?
_____ Yes _____ No

If "Yes," was it:

____ Outpatient ____ Inpatient ____ Day Hospital ____ Substance Abuse
____ Mental Health ____Psychological Testing ____ Psychiatric Evaluation

Name of Center/Individual **Address** **Year**

1. _____
2. _____
3. _____

Have you ever made a suicide attempt? _____ No ____ Yes If "Yes," in what year(s)?
_____

Have you ever had homicidal thoughts or experienced explosive, uncontrolled anger? ___ No ___ Yes If "Yes," describe:
_____

_____

Have you ever engaged in purposeful self-harm (e.g. cutting, burning self, etc.) _____ No ____ Yes
If "Yes," explain: _____

_____

Do you presently feel suicidal/homicidal (circle which)? ____ No ____ Yes If "Yes," explain: _____

_____

_____

ALCOHOL/DRUG USE

Do you currently drink alcohol/use drugs? ____ No ____ Yes If "Yes," how often? _____

Used alcohol/drugs in last 48 hours? ____ Yes ____ No If "Yes," how much? _____

Which alcohol/drug do you prefer? _____ How much usually each time? _____

List all the prescribed medications, over-the-counter drugs and street drugs you use now and have used in the past:

Prescriptions Over-the-Counter Street Drugs

_____

_____

_____

_____

Do you use alcohol and drugs together? ____ No ____ Yes If "Yes," for how many years? _____

Do you prefer to drink and/or drug: ____ Alone? ____ With Others?

Have you ever had a bad reaction (e.g., blackout, overdose, shakes) to a prescribed, over-the-counter, or street drug, or alcohol?) ____ No Yes ____ If "Yes," describe: _____

RELIGIOUS INVOLVEMENT

What is your religion? ___ Catholic ___ Protestant ___ Jewish ___ Muslim ___Hindu ___Atheist ___Agnostic
___ Other (specify) _____

How active are you in your religion: ____ Very ____ Some ____ Minimal ____ None

Are you satisfied with your degree of religious involvement? ____ Yes ____ No

ANY OTHER INFORMATION YOU WOULD LIKE TO ADD

_____

_____

_____

_____

Signature of Informant Date

I have reviewed this questionnaire with the patient/informant:

_____

Clinician's Signature/Credentials Date