BALANCE BEHAVIORAL HEALTH, PLLC

CONFIDENTIAL ADULT QUESTIONNAIRE

Please answer the following questions as completely as possible

Patient Name: _____ Date: _____

Main Issue you are seeking help with:_____

Medical/Lifestyle History:

Current Health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Medication(s) currently used:

Medication/Dose	Date Prescribed	Why Prescribed	Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Reproductive History: (Female Only)

Number of Pregnancies: _____ Number of Children: _____

Currently Pregnant: ☐ Yes ☐ No ☐ Maybe

Past Hospitalizations (Psychiatric/Chemical Dependency):

Date(s)	Reasons	Hospital
_____	_____	_____
_____	_____	_____

Alcohol Use:

How often do you use alcohol? ☐ None ☐ Monthly ☐ Weekly ☐ Daily

On the days that you drink, how many drinks do you usually have?

☐ Less than 2 ☐ 2-5 ☐ 5 or more

Do you consider it a problem? ☐ No ☐ Yes

Do others consider it a problem? ☐ No ☐ Yes

Do you have problems at work/school because of drinking or drug use? ☐ No ☐ Yes

Have you had problems with alcohol in the past? ☐ No ☐ Yes

Nicotine Use:

Do you smoke or use tobacco now? ☐ No ☐ Yes

How much? _____ How Long? _____

Have you smoked or used tobacco in the past? ☐ No ☐ Yes

How much? _____ How Long? _____

Caffeine:

How much cups of caffeinated coffee/tea do you drink a day? _____

How many caffeinated soft drinks? _____ How much chocolate, cocoa? _____

Drug Use:

Marijuana: ☐ None ☐ Occasionally ☐ Daily ☐ Weekly

Do you use other non-prescription substances? ☐ No ☐ Yes - what substance? _____

How often? ☐ Occasionally ☐ Daily ☐ Weekly

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Mental Health:

Is there a family history of (check all that apply):

☐ Alcoholism ☐ Substance Abuse ☐ Mental Illness ☐ Suicide

If yes, please describe the relationship to you and the problem:_____

_____

Have you attempted suicide? ☐ No ☐ Yes

Do you currently have suicidal thoughts? ☐ No ☐ Yes

Do you ever feel angry enough to do something that you might regret? ☐ No ☐ Yes

Childhood History:

As a child did you have any problems with:

☐ Learning Disabilities	☐ No	☐ Yes	_____
☐ Hyperactivity	☐ No	☐ Yes	_____
☐ Bed Wetting	☐ No	☐ Yes	_____
☐ School Fears	☐ No	☐ Yes	_____
☐ Depression	☐ No	☐ Yes	_____
☐ Sexual or Physical Abuse	☐ No	☐ Yes	_____

Did you have any other major childhood (0-17 years) school, learning, or emotional problems?

☐ No ☐ Yes - If yes, please describe:_____

_____

Family History:

Which of the following best describes the family in which you grew up?:

Warm and Accepting				Average			Distant, Hostile and Fighting	
1	2	3	4	5	6	7	8	9

Was the family/home disrupted by serious illness/accident/death/separation/divorce?

☐ No ☐ Yes - If yes, please describe:_____

_____

Legal History:

☐ None ☐ Litigation ☐ Arrest ☐ Victimization, specify_____

Job Satisfaction:

Place of Employment: _____

Job Title: _____

☐ Very Satisfied ☐ Fairly Satisfied ☐ Not At All Satisfied

Have you ever taken work leave for mental health/chemical dependency problems?

☐ No ☐ Yes, how long _____

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Previous Counseling, EAP, or Chemical Dependency Services:

Have you ever seen anyone or are you currently seeing anyone for:

Individual Therapy ☐ No ☐ Yes Marital/Couples Therapy ☐ No ☐ Yes

Group Psychotherapy ☐ No ☐ Yes Sex Therapy ☐ No ☐ Yes

If Yes, please list:

Facility/Counselor Name	Dates Seen	Reason Seen	Helpful?
_____	_____	_____	☐ No ☐ Yes
_____	_____	_____	☐ No ☐ Yes

Gender/Orientation:

Sexual Orientation: _____

Preferred Gender: _____

Preferred Pronouns: _____

Current Living Situation:

Married ☐ Divorced ☐ Separated ☐ Single ☐ Living with Someone ☐

List all persons living in the home:

NAME	DOB	RELATIONSHIP TO YOU	GENDER	GRADE/JOB

Any other information that you think may be helpful to know about you:

_____

_____

_____

_____

_____

_____

_____

_____

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Symptom Checklist

Please check all of the following problems/symptoms which pertain to you.

( ) panicky feelings
( ) nervousness
( ) anxiety
( ) fears
( ) phobic avoidance
( ) procrastination
( ) nervous tics
( ) driven to perform certain behaviors
( ) headaches
( ) chest pains
( ) rapid heart beat
( ) dizziness
( ) excessive sweating
( ) appetite problems
( ) weight loss/gain
( ) bowel/stomach trouble
( ) binging
( ) vomiting
( ) purging
( ) muscle tension
( ) physical pain
( ) hearing problems
( ) menstrual problems
( ) sexual problems
( ) drug/alcohol abuse
( ) depression
( ) unhappiness
( ) seasonal variations in mood
( ) tearfulness
( ) loss of interest
( ) sleep problems
( ) nightmares
( ) fatigue
( ) low self-esteem
( ) memory problems
( ) reduced concentration
( ) withdrawal
( ) no sense of purpose
( ) shyness
( ) loneliness
( ) relationship problems
( ) job problems
( ) educational problems
( ) financial problems
( ) career issues
( ) boredom
( ) temper outbursts
( ) anger problems
( ) loss of control
( ) suspicious of others
( ) hearing unidentified voices or sounds
( ) guilt
( ) jealousy
( ) difficulty making decisions
( ) homicidal thoughts
( ) suicidal thoughts
( ) history of abuse
( ) flashbacks
( ) time loss
( ) feeling out of body
( ) feeling unreal
( ) smelling unidentified odors
( ) sensitivity to noise or lights
( ) racing thoughts