Adult Questionnaire – Version 1

Please complete this questionnaire to the best of your ability for us to better understand how to help you today.

Preferred Name: _____ Age: _____

Preferred Pronouns: _____ Preferred Gender Identity: _____

Why did you choose to come in for services today? How are you hoping we can help you?

Were you referred for services today (ie: school, physician, hospital, police, probation, courts, etc.)?

❍ **No** ❍**Yes -** ***If yes, by whom?***

MENTAL HEALTH

Please describe any mental health symptoms or difficulties that you have experienced within the past month:

Have you been diagnosed/treated for any of the following mental health disorders? ❍ No ❍ Yes ***(check all that apply)***

❍ Anxiety Disorder	❍ Depression	❍ Post Traumatic Stress Disorder	❍ Intellectual Disability
❍ Attention Deficit Hyperactivity Disorder	❍ Eating disorder	❍ Schizophrenia	❍ Developmental Disability
❍ Bipolar Disorder	❍ Personality Disorder	❍ Schizoaffective Disorder	❍ Other: _____

Have you received, or are you currently receiving, any of the following services/treatment? ❍ No ❍ Yes ***(check all that apply)***

❍ Outpatient services	❍ Intensive Outpatient Services	❍ Sex offender treatment
❍ Mental Health Skill Building	❍ Partial Hospitalization Program	❍ Domestic violence treatment
❍ Mobile Crisis Stabilization	❍ Psychiatric hospitalization	❍ Other: _____
❍ Crisis Stabilization Unit	❍ Anger management	

If yes to any of the above, where have you received treatment?

Approximate Date of Admission/Discharge	Name of Provider, Practice, or Facility

Have you experienced or witnessed any of the following traumatic events in your lifetime? ❍ No ❍ Yes ***(check all that apply)***

❍ Verbal abuse	❍ Neglect	❍ Major vehicle accident	❍ Domestic violence
❍ Emotional abuse	❍ Bullying	❍ Industrial accident	❍ Violent crime
❍ Physical abuse	❍ Parental addiction	❍ Head injury/TBI	❍ Community violence
❍ Sexual abuse	❍ Parent's death in childhood	❍ Suicide	❍ Homicide
❍ Rape/Sexual assault	❍ Miscarriage	❍ Self-harming behaviors	❍ Natural disaster

❍ Other: _____

SUBSTANCE USE

Please indicate below if you have used or are currently using the following substances:

Type of Substance	How much?	How often?	How do you use it? *(smoke, oral, inhale, ingest, IV)*	Age of First Use	Date of Last Use
❍ Tobacco/Nicotine					
❍ Alcohol					
❍ Marijuana					
❍ Ecstasy/Molly, LSD, PCP, Spice, Mushrooms, or other Hallucinogens					
❍ Amphetamine/Speed					
❍ Cocaine/Crack					
❍ Heroin					
❍ Methadone/Suboxone (not prescribed)					
❍ Opiates					
❍ Benzodiazepines (Xanax, Ativan, klonopin)					
❍ Barbiturates (Fiorcet, Seconal, Tuinal, etc.)					
❍ Other:(Gabapentin/Neurontin, inhalants, etc					

Have you ever received any of the following treatments? ❍ No ❍ Yes ***(check all that apply)***

❍ Outpatient services ❍ Recovery House/Oxford house ❍ Residential Treatment
❍ Intensive Outpatient Services ❍ Inpatient Detox ❍ Other: _____
❍ Partial Hospitalization Program ❍ Medication Assisted Treatment (ie: methadone, naltrexone, suboxone, vivitrol)

If yes to any of the above, where have you received treatment?

Approximate Date of Admission/Discharge	Name of Provider, Practice, or Facility

Has anyone expressed concern about your substance use? ❍ No ❍ Yes

Do you feel like you have a problem with substances? ❍ No ❍ Yes

Have you experienced withdrawal symptoms for any substances you have or are using? ❍ No ❍ Yes ***(check all that apply)***

❍ Seizures ❍ Tremors/shakes ❍ Sweating ❍ Diarrhea/bloody stools
❍ Delirium tremors ❍ Muscle aches/pains ❍ Increased tolerance ❍ Other: _____
❍ Hallucinations ❍ Nausea/vomiting ❍ Binge use pattern

GENERAL AND MEDICAL HISTORY

Do you have any chronic medical conditions? ❍ No ❍ Yes *(check all that apply)*

❍ Alzheimer's Disease	❍ Anemia	❍ Arthritis	❍ Asthma
❍ Blood disorder/Sickle Cell	❍ Bowel disorder/IBS	❍ Cancer	❍ Cardiac Disease
❍ Chronic Pain	❍ Chronic fatigue	❍ Dementia	❍ Dental condition
❍ Diabetes	❍ Epilepsy	❍ Fibromyalgia	❍ Hepatitis A, B, or C
❍ Headaches/Migraines	❍ Hearing loss	❍ Hyper/hypothyroidism	❍ High/low blood pressure
❍ High cholesterol	❍ Kidney disease	❍ Hypoglycemia	❍ Lyme disease
❍ Liver disease	❍ Pancreatic disease	❍ Muscle strain	❍ Myocardial infarction/heart attack
❍ Stomach ulcers/GI problems	❍ Pregnancy	❍ Stroke	❍ Sexually transmitted disease

❍ Other: _____

Are you currently taking any prescribed medications? ❍ No ❍ Yes

If yes, please list below or provide a copy of medication administration record.

Medication	Start Date	Dosage & Frequency	Rationale	Provider	Helpful? Yes/No

Have any of the reported symptoms above impacted the following areas of your life? ❍ No ❍ Yes *(check all that apply)*

❍ Healthcare practices	❍ Managing money/belongings	❍ Leisure	❍ Coping skills
❍ Housing stability	❍ Nutrition	❍ Community resources	❍ Behavior norms
❍ Communication	❍ Problem solving	❍ Social network/friends	❍ Personal hygiene
❍ Safety	❍ Family relationships	❍ Sexuality	❍ Grooming
❍ Managing time	❍ Alcohol/drug use	❍ Productivity	❍ Dress

If yes to any of the above, please briefly explain:

Are there any concerns about intimate relationships, sexuality, and/or gender identification that you would like to discuss?

❍ No ❍ Yes – *if yes, please describe:*

Is there any additional information that you feel would be helpful during the assessment process?

❍ No ❍ Yes – *if yes, please describe:*