DELAWARE COUNTY BEHAVIORAL HEALTH

MENTAL HEALTH SERVICES
FAMILY & CHILDREN SERVICES
ADDICTION SERVICES

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ADULT QUESTIONNAIRE

Date: _____ **Client Name:** _____

Presenting Concerns: Why did you contact the clinic now? _____

History of Mental Health Treatment: Have you ever seen a therapist or been psychiatrically hospitalized? If so, who was your provider and how long were you in treatment?_____

Was it helpful or not helpful while in treatment? _____

History of Substance Abuse Treatment: Have you ever seen a substance abuse counselor or been in rehab? _____If so, who was your provider and did you complete treatment? _____

Living Situation: Who lives with you? Please provide first and last name, age and relationship to you.

Do you have children who do not live with you? If so please list name, age and where they live.

Life Stressors: Please check any stressors that are a problem for you now.
☐relationship problems ☐verbal or emotional abuse ☐physical abuse ☐sexual abuse
☐financial concerns ☐health concerns ☐employment concerns ☐legal concerns
Please provide a brief description of stressors:_____

_____

_____

Legal Issues/History: Please provide a brief history of any legal issues: _____

_____

_____

Life Supports: Who can you turn to for support? _____

_____

What do you do for fun? _____

_____

Do you identify with any religious or spiritual beliefs? _____

_____

Childhood/Adolescent Development: (please provide first and last name, even if deceased)
Mother:_____ Age:_____ Town:_____
Father:_____ Age:_____ Town:_____
How would you describe your mother? _____
How would you describe your father? _____
Brothers and sisters: (please provide first and last name, age and town or state of residence)
Name: _____ Age:_____ Town:_____
Name: _____ Age:_____ Town:_____
Name: _____ Age:_____ Town:_____
Name: _____ Age:_____ Town:_____
Name: _____Age:_____ Town:_____

Childhood Stressors: Please check any stressors experienced during childhood.
☐relationship problems ☐verbal or emotional abuse ☐physical abuse ☐sexual abuse
☐problems with schoolwork ☐difficulty getting along with other children ☐moving often
☐difficulty getting along with teachers ☐financial problems

Please provide a brief description of childhood stressors or problems: _____

_____

_____

Were you diagnosed with a learning disability during childhood? _____If so, please describe:

_____

_____

_____

Childhood Supports: Who could you turn to for emotional support during childhood?

_____

_____

_____

Problems you may be struggling with: Please check all that apply to you.

- ☐ Do you get suddenly overwhelmed?
- ☐ Do you get shortness of breath?
- ☐ Do you experience rapid heartbeat?
- ☐ Do you get shaky, dizzy or lightheaded?
- ☐ Are you fearful in crowds of people?
- ☐ Are you afraid to leave your home?
- ☐ Sexual problems
- ☐ Eating problems
- ☐ Death of a loved one
- ☐ Major losses/difficult changes
- ☐ Difficulty concentrating
- ☐ Feeling guilty, worthlessness or hopeless
- ☐ Problems remembering things
- ☐ Fatigue/low energy
- ☐ Withdrawing from others
- ☐ Hyper/too much energy
- ☐ Loss of interest in things I used to enjoy
- ☐ Low self-esteem
- ☐ Worry all the time
- ☐ People picking on me
- ☐ Can't stop washing hands/body, counting or checking things
- ☐ Moody or crying more than usual
- ☐ Compulsive gambling
- ☐ Anger or temper problems

Sleep problems:

- ☐ Difficulty falling asleep
- ☐ Waking in the middle of the night
- ☐ Sleeping too much
- ☐ Nightmares

Appetite Problems:

- ☐ Changes in appetite
- ☐ Weight loss (___# in ___weeks)
- ☐ Not hungry or not eating
- ☐ Feeling sick to your stomach
- ☐ Constipation or diarrhea

Self-Harm:

- ☐ I cut myself
- ☐ I burn myself
- ☐ I hit myself
- ☐ Other (explain_____)

Hallucinations:

- ☐ I hear things
- ☐ I see things
- ☐ I smell things
- ☐ I feel things

How long have your struggled with these problems? _____

_____

Safety: Do you have suicidal thoughts? ☐ YES ☐ NO
Do you have homicidal thoughts? ☐ YES ☐ NO
Do you have access to firearms? ☐ YES ☐ NO
Have you ever tried to harm yourself or others?_____ If so, please explain_____

_____

_____

Treatment goals: What are your goals for treatment? _____

_____

_____

How will you know when you are better? _____

_____

_____