ADULT HISTORY QUESTIONNAIRE

Name: ________________________________**Age:** ______ **Gender:** _________ **Today's Date:** _____________

Date of Birth: _____________**Race:**_____________________

Address:__________________________ **Phone:**________________ **Is it okay to leave a message?** ___**Yes** ____**No**

____________________________ **Phone:** _______________ **Is it okay to leave a message?** ___**Yes** ____**No**

Emergency Contact:_________________________ **Phone:** ___________________ **Relationship:**________________

Current Marital Status: ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed** ☐ **Single (never married)**

Are you employed ❑ **No** ❑ **Yes** **If yes, how many hours per week?** ______ **What do you do** _________________

Are you experiencing problems at work ❑ **No** ❑ **Yes** **If yes, describe** ____________________________________

____

Do you attend school: ❑ **No** ❑ **Yes** **What is the highest level of education you completed**___________________

Do you have a history of military service ❑ **No** ❑ **Yes** **If yes, what branch and years of service**______________

Primary Household
(Who currently lives in your home)

Name	Relationship to you	Age	Quality of relationship

Were you referred to Recovering Hope (if yes, who and for what reason): __________________________________

What led you to seek our services? ____

____

____

When did this problem begin? ____

How often does this problem occur?
- O Daily
- O Some days
- O Most days
- O Under certain circumstances

How severe is the problem now?
(on a scale 1 to 10; 1 is the lowest and 10 is highest)

←---→
1 2 3 4 5 6 7 8 9 10
Low Medium High

Have you experienced any of the following (please check):

- € Previous mental health issues or evaluation
- € Psychiatric hospitalization
- € Suicide attempt(s)
- € History of self-injurious behavior
- € Prior mental health diagnosis
- € Prior mental health treatment
- € War
- € Crime victim
- € Unhappy childhood
- € Out of home placement as a child
- € Legal Issues
- € Victim of abuse:
  - € Physical
  - € Sexual
  - € Emotional
- € Threats of violence towards others

Please describe any of the items endorsed above: ____

____

Checklist of Current Concerns (Please check all that apply)

❑ Alcohol use
❑ Anger, hostility, arguing, irritability
❑ Anxiety, nervousness, panic, phobias, fear
❑ Attention, concentration, distractibility
❑ Career concerns, goals, and choices
❑ Childhood issues (your own childhood)
❑ Confusion
❑ Decision making, indecision, mixed feelings, putting off decisions
❑ Dependence
❑ Depression, low mood, sadness, crying
❑ Divorce, separation
❑ Drug use—prescription medications, over-the-counter medications, street drugs
❑ Eating problems—overeating, undereating, appetite, vomiting
❑ Fatigue, tiredness, low energy
❑ Financial or money troubles, debt, impulsive spending, low income
❑ Gambling
❑ Grieving, mourning, deaths, losses, divorce
❑ Guilt
❑ Headaches, other kinds of pains
❑ Health, illness, medical concerns, physical problems
❑ Housework/chores—quality, schedules, sharing duties
❑ Impulsiveness, loss of control, outbursts
❑ Irresponsibility
❑ Legal matters, charges, suits
❑ Loneliness
❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
❑ Memory problems
❑ Mood swings
❑ Motivation, laziness
❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
❑ Pain, chronic
❑ Parenting, child management, single parenthood
❑ Perfectionism
❑ Procrastination, work inhibitions, laziness
❑ Relationship problems (with friends, with relatives, or at work)
❑ Self-esteem
❑ Sexual issues
❑ Shyness, oversensitivity to criticism
❑ Sleep problems—too much, too little, insomnia, nightmares
❑ Smoking and tobacco use
❑ Spiritual, religious, moral, ethical issues
❑ Stress, relaxation, stress management, stress disorders, tension
❑ Suicidal thoughts
❑ Weight and diet issues
❑ Withdrawal, isolating
❑ Work problems, employment, workaholism/ overworking, can’t keep a job, dissatisfaction, ambition

Medical Health History

Please rate your current physical health: ________excellent ________good ________fair ________poor

Current primary care physician: ____

Date last seen by primary care physician: ______________________ Do you have allergies: ❑ No ❑ Yes

Please list all current prescription medications and dosages that you are taking and the purpose for each:

____

____

Please list all over-the-counter medications, vitamins, or supplements you are currently taking:_______________

____

Please list all current medical conditions:____

____

Please list all significant diseases, illnesses, accidents, injuries, head trauma, surgeries, and hospitalizations:

____

____

Healthy Eating

1. **Do you have access to enough healthy food to eat?** Yes No
2. **During a normal meal, is half the food on your plate fruit and vegetables?** Yes No
3. **On a scale of 1-10, how ready are you to eat more fruit and vegetables?** _____
   (10= extremely motivated; 1= no motivation at all)
4. **What concerns, if any, do you have with your eating habits?**
   ____
   ____

Active Living

1. **During a normal week, how often do you exercise enough to make your heart beat faster**? ____ minutes per day ____ days per week
2. O**n a scale of 1-10, how ready are you to exercise more?** _____
   (10= extremely motivated; 1= no motivation at all)

Substance Use (Please check all that apply)

Substance	Past Use	Current Use
Alcohol		
Tobacco		
Caffeine		
Marijuana		
Methamphetamine		
Narcotics		
Cocaine		
Heroin		
Prescription Drugs		
Other:		

CAGE-AID

1. Have you ever felt you ought to cut down on your drinking or drug use? ____Yes _____ No
2. Have people annoyed you by criticizing your drinking or drug use? ____Yes _____ No
3. Have you felt bad or guilty about your drinking or drug use? ____Yes _____ No
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? ____Yes _____ No

Do you use tobacco, including e-cigarettes? ❑ No ❑ Yes If yes, how many cigarettes/cigars/other do you use each day? ________
If yes, are you interested in smoking cessation ❑ No ❑ Yes
On a scale of 1-10, how ready are you to quit or use less tobacco? _____
(10= extremely motivated; 1= no motivation at all)

How much coffee, cola, tea, or other sources of caffeine do you consume each day? ____________________

Legal issues as a result of drug and/or alcohol use: _____ No ___ Yes Describe: ___________________________

____

Do you have a history of participating in a chemical dependency treatment program: ____ No _____ Yes

If yes, please describe when and where you were in treatment:____

Legal History

Do you have a history of legal charges: _______No ______Yes

If yes, please describe charges:____

____

Are you currently on probation: _____No _____Yes Have you ever been on probation: _____No _____Yes

Family History (please check if the following pertain to any of your family members)

Mental health issues
Significant family disruption
Alcohol abuse
Substance Use
Legal Issues
Physical health concerns/disabilities
Cognitive or learning disabilities
Financial stressors
Abuse Issues:
Victim
Perpetrator

Please describe any of the items endorsed above: ____

____

____

Please identify some of your strengths and interests: ____

____

Please provide any additional information you would like to share: ____________________________________

____