Dr. Heather Therapy, PLLC
Adult Questionnaire

Name: ________________________________ Today's Date: __________ Age: _____ Date of Birth: __________

Who referred you to me?____

Briefly describe the reason you're here: ____
____
____

Family
Marital Status
☐ Married ☐ Separated ☐ Divorced ☐ Widow How long?___________
☐ Single

Please describe previous marriage(s), if any: ____
____

Do you have children? ☐Yes ☐ No If so, how many? ____

If divorced who has custody? ☐ Mother ☐ Father ☐ Joint Custody ☐ Neither Specify:

Are any of your children adopted? ☐ Yes ☐ No

If yes, please describe the circumstances of the adoption:____

Have you lost a child? ☐ Yes ☐ No

Do any of your children have special needs? ☐ Yes ☐ No
If so, please describe:____
____

Please list all children and other adults living in your home:

Name	Age	Relationship

Do you have a history of violence in your house or in your relationships? ☐ Yes ☐ No

Is anyone that you are in a close relationship with abusing drugs and/or alcohol? ☐ Yes ☐ No

Please describe the circumstances of any of the above if marked yes: ___________________________
____
____

Work
Are you currently employed? ☐ Yes ☐ No Occupation _________________________________

Employer _______________________________ How long with this employer? __________________

How would you describe your current level of job satisfaction?
☐ Very Satisfied ☐ Satisfied ☐ Average ☐ Dissatisfied ☐ Very Dissatisfied

If you are not currently employed, which of the following describes you? (check all that apply)

☐ Student ☐ Retired ☐ Looking for work ☐ Stay-at-home parent

☐ Caring for sick/elderly relative ☐ Volunteer ☐ Other ________________

Education

If you are currently a student:

Name of School: ____ Year:______________________

Performance: ☐ Poor ☐ Fair ☐ Good

Highest degree completed to date: ☐ High School ☐ College ☐ Graduate/professional

☐ Technical Training ☐ Other ________________

Any known learning disabilities/attention problems? ☐ Yes ☐ No If Yes, when were you diagnosed and explain specific disabilities: ____

Therapy History

Have you ever received mental health related therapy? ☐ Yes ☐ No

How would you describe the effectiveness of this treatment?

☐ Much improvement ☐ Some improvement ☐ No improvement

Please describe any interventions you have previously received: ____

____

____

____

Have you ever taken psychiatric medication? ☐ Yes ☐ No

Medication	Dosage	Dates of Use	Prescriber	Benefits	Side Effects

Family Medical/Psychiatric History

Do medical illnesses run in the family? (example: seizures, thyroid problems, allergies) ☐ Yes ☐ No

If yes, please describe, specifying relationship to you and including treatment: ____________________________

____

____

____

Have any of your biological relatives had psychiatric problems? ☐ Yes ☐ No ☐ Don't know

(Please note any that apply: Major Depression, Bipolar Disorder, Obsessive-Compulsive Disorder, Tic Disorders, other Anxiety Disorders, Schizophrenia, Substance Abuse, Suicide Attempts, other Psychiatric problems.)

If yes, which biological relatives(s)? ☐ Mother ☐ Father ☐ Brother ☐ Sister

☐ Grandmother (maternal/paternal) ☐ Grandfather (maternal/paternal)

☐ Aunt (maternal/paternal) ☐ Uncle (maternal/paternal) ☐ Other (Specify:)

If yes, please describe problem(s), including treatment: ____

Outside of biological relatives, are there any other people with whom you have significant contact

who have psychiatric problems? ☐ Yes ☐ No ☐ Don't know

If yes, please specify the contact(s) and describe the problem(s), including treatment:

Health

Please list any significant childhood illnesses: ______________________________

Please list any surgery and when it was performed: ______________________________

Have you ever had a seizure, head trauma, or loss of consciousness? ☐ Yes ☐ No

If so, please describe: ______________________________

Have you ever been hospitalized? ☐ Yes ☐ No

If so, please describe: ______________________________

Have you ever been seen in the emergency room? ☐ Yes ☐ No

If so, please describe: ______________________________

Are you currently receiving treatment for a medical condition? ☐ Yes ☐ No

If so, please describe: ______________________________

Is your vision within normal limits? ☐ Yes ☐ No

Is your hearing within normal limits? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes, how many a day? ____________________

Do you engage in regular exercise/physical activity? ☐ Yes ☐ No

Are you happy with your current weight/level of fitness? ☐ Yes ☐ No

If no, why not? ______________________________

How often do you drink alcohol? ☐ Never ☐ Monthly ☐ Weekly ☐ Daily

Do you regularly use street drugs? ☐ Yes ☐ No

Do you consider yourself dependent on drugs and/or alcohol? ☐ Yes ☐ No

Describe your sleep: ☐ Excessive ☐ Restless ☐ Insomnia ☐ Fatigued ☐ No Difficulties

Additional Information: Please write anything else you wish to tell me on the back.