Authentic Self Psychotherapeutic Services
1920 Palm Beach Lakes Blvd., Suite 206 West Palm Beach, Florida 33401 561-207-7702

Adult Questionnaire

IDENTIFYING INFORMATION

Date: _____

Name: _____ SS#: _____

Gender: _____ DOB: _____ Age: _____

Race/Ethnicity: _____ Country of Birth: _____ Marital status: _____

Address: _____ Phone Number: _____
Street City, State Zip

Highest Education Completed: _____ Occupation: _____

Referral Source: _____ Phone Number: _____

Reason for referral: _____

CHIEF COMPLAINT

Please describe the major problem for which you are seeking help:

Presenting problem(s)	Onset
1.	
2.	
3.	

Additional information: _____

_____

PROBLEM CHECKLIST:

Please check all that apply (recently):

o Difficulty Concentrating	o Feelings of sadness	o Headaches
o Seeing things that aren't there	o Hopelessness	o Problems sleeping
o Hearing things	o Feel useless	o Anger
o Trouble w/ memory	o Feel lonely	o Loss of appetite
o Distrustful	o Law breaking	o Eating disorder
o Unreasonable fears	o School problems	o Drugs/alcohol
o Panic attacks	o Anxious/Tense	o Relationship problems

Have you ever received treatment from a therapist, psychologist, or psychiatrist in the past? If so, please describe:

Date	Length of time	Chief complaint?	Services Provided	Diagnosis (if any)

MEDICAL/PSYCHIATRIC TREATMENT

Have you recently had changes with:

Symptom	Response	Descriptor	Additional Information
Weight Loss / Gain	Yes _____ No _____	Number of pounds	
Appetite	Yes _____ No _____	Increase / Decrease	
Sleep disturbances	Yes _____ No _____	Insomnia / Hypersomnia	
Loss of interest in normal activities	Yes _____ No _____		

PERSONAL / FAMILY/ SOCIAL

Father's Name: _____ _____ Occupation: _____ Age: _____

Mother's Name: _____ Occupation: _____ Age: _____

Parent's Marital Status: Married Divorced Separated Never Married

Siblings (Names/ages):_____

Family history of psychiatric illness: yes/no
If yes, please describe: _____

Current living arrangements? _____

Have you ever been a victim of physical abuse? Yes_____ No _____ Explain: _____

_____

Have you ever been a victim of sexual abuse? Yes _____ No _____ Explain: _____

_____

Do you have current or past medical conditions/illnesses/hospitalizations? If so, please describe:

Date	Length of treatment	Illness/ Reason for hospitalization	Outcome

Name of Primary Care Physician: _____ Telephone #: _____

Are you currently taking any medications (for physical or mental health conditions):

Name of medication	Dosage	Frequency

Are medications being taken as prescribed? Yes _____ No _____

When are these medications taken (time of day) _____

SUBSTANCE USE

Substance	Age of first use	Frequency of use	Route of administration	Date of last use
Tobacco				
Caffeine				
Marijuana				
Cocaine				
Opiates				
Heroine				
Benzodiazepines				
Amphetamines				
Methamphetamines				
Other: _____				

LEGAL INVOLVEMENT

Have you ever been involved with the police or court system? Yes _____ No _____

If yes, please describe: _____
_____

Do you have any charges pending? Yes _____ No _____

MENTAL STATUS

(To be completed by clinician)

Appearance	Appropriate	Disheveled	Bizarre	Nervous	Guarded	Tremulous
Mood	Euthymic	Anxious	Depressed	Angry	Euphoric	Irritable
Affect	Full	Constricted	Blunted	Flat	Labile	Approp. to mood
Thought Process	Normal	Logical	Disorganized	Tangential	Circumstantial	Flight of Ideas
Memory	Oriented X4	Disoriented	Recent: Normal ___ Impaired ____		Remote: Normal ___ Impaired ___	