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ADULT QUESTIONNAIRE

Today's date: _____

Name:_____ Gender: _____ Age: _____ Birthdate: _____
Address: _____ City: _____ Zip Code: _____
Home Phone Number: _____ Cell Number: _____
Work Number: _____ Ok to leave messages at these numbers? _____

Occupation/Place of Employment: _____
Insurance (Name, Group #, Individual #): _____
_____
Responsible party, if other than yourself: _____
Relationship to you: _____

____ Single ____ Married; how long? _____ _____ Coupled, not married; how long ____
____ Separated; how long? _____ _____ Divorced _____ Widowed
Any previous marriages? _____

Current spouse or partner: _____ Age: _____ Birthdate: _____
Employer: _____ Insurance: _____

Children: _____ Age: _____ Grade/School: _____
_____ Age: _____ Grade/School: _____
_____ Age: _____ Grade/School: _____
_____ Age: _____ Grade/School: _____

1. Please describe any prior therapy you have received, including name(s) of therapist, nature of problem, dates of attendance:

2. Please describe the present problem(s):

3. What are your goals for seeking treatment at this time?

4. Please describe any health problems:

Do you smoke: _____ If so, how much a day/week? _____
Do you use recreational drugs: _____ If so, what kind and how often do you use?
_____
Do you use alcohol? _____ If so, how much a day/week?
Ever attended outpatient chemical dependency treatment? _____ If so, when? _____
Ever attended inpatient chemical dependency treatment? _____ If so, when? _____
Any pending legal issues? _____
Sleep issues? _____ Please describe: _____
Appetite/weight issues? _____ Please describe: _____
Current physician (name and phone): _____

List all current medications, including dosage, when you take, how long you have been taking it, and what condition the medication was prescribed to treat:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Anything else you'd like to share?