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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? _____________
Ok to receive texts on Cell Number? _________
Email ____________________________________ Ok to leave messages on email? ______________

WORK

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

RELATIONSHIPS

____ Single ____ Married; Married how long? _______

_____ Coupled, not married; Coupled how long? ______

_____ Separated; how long? _____
_____ Divorced; how long?_____
_____Widowed; how long?

Previous marriages/briefly explain: ____

Current spouse or partner: ________________________ Age: _____ Birthdate: _____________
Employer: ____ Insurance: ________________________

Children: ______________________________ Age: _______ Grade/School: ___________________
______________________________ Age: _______ Grade/School: ___________________
______________________________ Age: _______ Grade/School: ___________________
______________________________ Age: _______ Grade/School: ___________________

THERAPY

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?

HEALTH and WELLNESS

1. Please describe any health problems/hospitalizations:

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?

Sleep issues? _________ Please describe:

Appetite/weight issues? ________ Please describe:

Current physician (name and phone):

Any pending legal issues? _________

Any current/past suicidal/homicidal thoughts/gestures? __________ If yes, please describe:

2. 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. ____

Is there anything else that would be helpful for me to know?