Julie Kotler, LCPC, LCPAT, ATR-BC

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Approved Supervisor #890
Psychotherapy and Mental Health Services
For Lifelong Wellness
301-793-1520
Tax ID # 27-4942552

ADULT HISTORY QUESTIONNAIRE

Please bring this completed form with you at the time of your initial appointment.

REFERRAL INFORMATION

Name _____
Birth Date _____ Age _____ Sex _____
Home Address _____
_____
Home Phone Number (_____)_____
Work Phone Number (_____)_____
Cell Phone Number (_____)_____
Email Address _____
By whom where you referred? _____

Person we should contact in the event of an emergency:
Name _____ Relationship _____
Phone Number (_____)_____

Describe your major concerns, including duration of those concerns and any previous attempts to resolve them.

_____
_____
_____
_____
_____

I

Indicate with a check mark how severe your concerns are at this point in time:
_____ mildly upsetting _____ moderately severe _____ very severe _____ extremely severe _____ incapacitating

Please describe below any major life stressors that have occurred to you or your family during the past year.

_____
_____
_____

What goals do you have for your treatment?

_____
_____
_____
_____

List past and/or present counseling and evaluation services:
Counselor Dates Seen Records Available?
_____
_____
_____
_____

Medical Development History

Primary Care Physician: Name _____
Address _____
_____
Phone (_____)_____
Present or Chronic Illnesses:
_____
Current Medications (indicate dosage and prescribing physician):
_____
_____
Past Psychiatric Medications: Medication Dose Response Why stopped
_____
_____

Allergies: _____

Please indicate with a check mark if your childhood/adolescent/young adult history includes any of the following:
____ birth complications ____ major childhood illnesses ____ major childhood injuries
____ major childhood stresses ____ head injury (major or minor) ____ seizures
____ substance or alcohol abuse ____ childhood anxiety ____ childhood depression
____ allergies____ attention difficulties ____ victim of sexual abuse
____ victim of physical abuse ____ difficult family situation
____ problematic childhood/adolescence ____ childhood behavior problems
____ childhood legal problems ____ learning disabilities ____ parental separation/divorce
____ adoption

Please provide details concerning checked items:

Educational/Occupational Information

EDUCATION
Highest grade completed in school, including degrees earned (indicate subject major).
_____
Describe your academic strengths.
_____
_____
Describe any academic difficulties.
_____

Compared to other students you went to school with as a child, how would you rate your overall intelligence level?
____ below average ____ average ____ above average ____ gifted

OCCUPATION

Describe your current employment position _____
_____
_____
Number of years _____

List other positions you have held: Type of Job Years
_____
_____

Are you satisfied with your present work? _____

If not, in what ways are you dissatisfied? _____
_____

INTERESTS
Describe your present interests or hobbies.
_____
_____

Present Areas of Concern

All people encounter difficulties from time to time. Please indicate with a check mark those areas of concern which you believe pose particular challenges for you.

TENSIONS/WORRIES
____ fearful ____ panicky ____ feeling keyed up or on edge ____ easily fatigued ____ difficulty concentrating ____ repetitive worries ____ repetitive actions to prevent stress ____ fear of dying ____ irritable ____ frequent stomachaches ____ frequent headaches ____ specific fears (indicate _____)

EMOTIONS ____ sadness or tearfulness
____ low self-esteem ____ lack of enjoyment/interest ____ low energy ____ feelings of worthlessness ____ feelings of guilt ____ grieving ____ feeling hopeless ____ over-excited ____ under-excited ____ angry ____ slow-moving/under-active ____ moody ____ difficulty controlling temper ____ thoughts of hurting self ____ thoughts of doing something uncontrolled

OTHER ____ career indecision
____ identity issues ____ eating problems ____ weight loss or gain ____ substance abuse ____ excessive use of alcohol ____ unusual thoughts or feelings ____ legal problems

ATTENTION/LEARNING ____ memory difficulties
____ disorganization ____ difficulty with attention ____ lose things frequently ____ easily distracted ____ forgetful ____ fidgety ____ feelings of restlessness ____ act without thinking ____ learning disability ____ difficulty reading ____ difficulty writing ____ difficulty understanding what others say

INTERPERSONAL STRESSES ____ lonely or isolated
____ difficulty with coworkers ____ difficulty with boss ____ difficulty with family ____ difficulty with friends

REACTIONS/LIFESTYLE ____ too emotional
____ under emotional ____ like to be center of attention ____ hard to trust others ____ feel people talk about me ____ avoid people when possible ____ fear of criticism ____ difficulty with decisions ____ fear others will abandon me ____ difficulty doing things on own ____ perfectionistic ____ overly focused on work ____ rigid/stubborn ____ fluctuating, unstable relationships ____ reckless ____ feelings of emptiness ____ difficulty following rules ____ physically aggressive ____ preoccupied with fantasies of success ____ special talents ____ eccentric

Please elaborate on any items above and specify any other concerns.

Family History

HOUSEHOLD List household members' names, ages, and any concern you may have.

Name Age Relationship Medical/School/Behavior concern

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

MARITAL STATUS

____Single ____Engaged ____Married ____Re-married ____Separated ____Divorced ____Widowed

Spouse's age _____ Spouse's occupation _____

Length of relationship _____

Describe strengths of current relationship _____

_____

_____

Describe areas of concern or incompatibility in the relationship _____

_____

_____

Give details of any previous marriages (length, children) _____

_____

_____

HISTORY OF EXTENDED FAMILY

Parents

Mother's occupation _____Highest grade completed _____

Father's occupation _____ Highest grade completed _____

Parental marital status: ___Not Married ___Married ___Separated ___Divorced ___Widowed

If applicable, your age at time of parental separation or death _____

Siblings Number of siblings ____

Your birth order: ____youngest ____middle ____oldest ____other

Extended Family History

Please indicate with a check mark whether there is a family history of any of the following difficulties. Include parents, siblings, grandparents, aunts, uncles, and cousins. If present, please specify relationship.

Difficulty

____ Mental Retardation ____ Attention Deficit Disorder/Attention Problems ____ Tourette's Syndrome or Tic Disorder ____ Learning Problems/Failure ____ Communication Difficulties ____ Autism/Autistic Spectrum ____ Anxiety Problems ____ Obsessive Compulsive Disorder ____ Depression ____ Suicide Attempt, Suicide Completed ____ Sexual or Physical Abuse ____ Drug Abuse ____ Alcoholism ____ Legal Difficulties ____ Schizophrenia ____ Psychiatric Hospitalization ____ Use of Psychiatric Medication ____ Thyroid Problems ____ Genetic/Metabolic Disorders ____ Bipolar Disorder ____ Personality Disorder

Please give a word-picture of yourself as you would be described by:
(a) spouse or significant other_____
(b) your best friend _____
(c) someone who dislikes you _____
(d) self-description _____

ADDITIONAL COMMENTS
Please use the space below to describe any other information you feel would be helpful to us in understanding your concerns.