Adult History Questionnaire

Person Completing Form: _____ Date: _____

Please answer the following questions to help us learn about your background. Feel free to use the backside of each page if you need more room.

1. Why are you requesting services at this time?

2. Have you received mental health services in the past? ____Yes ____No
   If yes please list the provider and the dates:

3. Have you been on any medications in the past you feel are relevant to our services? Yes____ No____ If yes, please list.

4. Are you on any medications? If yes, please list them below.

Name	Dose	How long have been on	Prescribed by

5. Have any of your family members had any mental health concerns?

6. Please answer these questions about health problems you and family members have:

You			Family Member Has
Yes	No		Yes
____	____	Allergies	____
____	____	Diabetes	____
____	____	Hypertension	____
____	____	Cancer	____
____	____	ADHD	____
____	____	Hearing Loss	____
____	____	Vision Problems	____
____	____	Epilepsy/Seizures	____
____	____	Asthma	____
____	____	Heart Disease	____
____	____	Stroke	____
____	____	Lung Disease	____
____	____	Migraines	____
____	____	Arthritis	____
____	____	Other	____

Describe any other conditions: _____

7. Who is your family physician?_____

8. Please list any additional parties you feel may need to be or currently are involved with your care.

9. Are there any legal proceedings pending on your behalf? Yes____ No____
If yes, please list.

NOTE: Your therapist/doctor will ask you to sign a Release of Information form if they need to communicate with any of the people listed on this form.