ADULT HISTORY QUESTIONNAIRE
(CONFIDENTIAL)

The information that you provide on this confidential questionnaire will be used to provide Dr. Lane with information to assist him in forming a complete and accurate clinical understanding of you and your situation. Please complete this form to the best of your knowledge. If you are unable to answer a question, you may leave it blank and discuss the information when you meet with Dr. Lane. Please complete all pages, using additional pages if needed to answer the questions.
Thank you for your assistance.

IDENTIFICATION:
Full Name:_____ Date of Birth____/____/_____Age_____
Gender _____Race/Ethnicity_____
Sexual Orientation_____
Home Address _____
City, State, Zip Code _____
Home Telephone number _____Cell Phone number _____
Work Telephone Number_____
Preferred Email:_____
How did you hear about Dr. Lane? _____
How may Dr. Lane contact you and leave an identifying message (check all that apply)?
___ home phone ___ cell phone ___ work phone ____mail ____ email

In case of an emergency, who may Dr. Lane contact?
Name: _____ Relationship: _____
Phone number: _____

CURRENT SITUATION:
1.) Please state in your own words the nature of your present concern:
_____
_____
_____
_____
_____
_____
_____

2.) What event/crisis brought about this request for Dr. Lane's assistance?
_____
_____
_____
_____
_____
_____.

3. Briefly describe your goals and expectations for therapy and what you hope to accomplish by working with Dr. Lane:

_____
_____
_____
_____
_____
_____.

4. Have these concern(s) affected (check all that apply):
____Family and personal relationships ____ Job performance
____ Social relationships ____ Health
____ Other: (explain)_____

5. How long have these problems existed? _____
_____

6. With whom do you usually discuss your problems or worries? _____
_____

BACKGROUND:
1) Number of years of education completed: _____ Degree: _____
2. Briefly describe how you felt about school?_____
_____
_____
_____

3. Your current employment: Circle if N/A.
Employer: _____
Job Title: _____
Length of Employment: _____
_____

4. Partner's Current Employment:
Employer: _____
JobTitle:_____
Length of Employment: _____

5. Currently, I am:
___ Single ___ Divorced ___ Married ___ Widow/Widower ____Other

6. My most recent/current spouse or partner (significant other) is/was:
Full Name: _____

7. We have/had been together for _____ years _____ months
Are you married? YES / NO
If yes, for how long? _____

8. How has/was this relationship been accepted by both sets of parents?

_____

_____

_____

9. Please provide the following information regarding your immediate family (e.g., parents, brothers, sisters, spouse, children, etc.) and others living with you currently.

Name	Age	Relationship	Occupation	Education *	Living/ deceased?**	Living with you now? (check if yes)

- 1- Less than H.S 2 -High School 3-Some College 4-College Degree 5-Higher

** Check if living, put year if deceased.

---------Continue on another sheet if necessary.

11. If (either of) you have been married before, please give dates and cause/s for the termination: _____

---

12. If your parents are (were) divorced, please give date, cause(s):

_____

_____

_____

_____

13. List any subsequent marriages by either of your parents:

_____

_____

_____

_____

14. Please check any of the following that apply to you in the last 2 weeks

___ sleep difficulties	___ emotional abuse
___ academic/school concerns	___ physical abuse
___ trouble concentrating	___ binge eating
___ problems with alcohol	___ laxative use
___ change in appetite	___ dizziness
___ problems with drugs	___ unable to relax
___ often feel hopeless	___ cutting/self-injurious behavior
___ difficulties with parents	___ nightmares
___ not assertive enough	___ dislike weekends/vacations
___ difficulties with child(ren)	___ difficulty in social situations
___ often feel anxious	___ panic attacks ____times/week
___ decreased interest in things	___ sexual problems
___ anger problems	___ worry too much
___ mood swings	___ discrimination/harassment
___ restricting food intake	___ sexual assault/rape survivor
___ over-exercising	___ career indecision
___ suicidal thoughts	___ self-esteem problems
___ legal problems	___ weight loss
___ often feel stressed	___ weight gain
___ often feel irritable	___ financial concerns
___ don't trust people	___ weight concerns
___ flashbacks	___ loss of a significant person
___ crying spells	___ racial identity issues
___ loss of interest	___ physical health concerns
___ often feel guilty	___ difficulties with boss
___ sexual identity issues	___ eating disorder
___ religious/spiritual concerns	___ headaches
___ want to avoid people	___ chronic or acute illness
___ difficulty expressing emotions	___ often feel overwhelmed
___ loss of menstrual periods	___ chronic or acute pain
___ feel emotionally numb	___ problems with partner/spouse
___ body image concerns	___ relationship violence
___ feel lonely	___ family of origin issues
___ difficulty making decisions	___ self-confidence problems
___ decrease in motivation	___ problems with friends
___ job concerns	___ other:_____
___ sexual abuse	___ other:_____
___ emotional abuse	___ other:_____
___ physical abuse	

15. How do you usually express your anger? _____
_____
_____

16. With whom are you most often angry with? _____
_____
_____

17. Legal history:
Number of arrests: _____
When? _____ What were you arrested for?_____
_____
_____

MEDICAL:
1. Have any of your family members received psychiatric care? YES / NO
If yes, please describe:
_____
_____
_____
_____

2. List any significant illnesses, hospitalizations or surgical procedures you have experienced: _____
_____
_____
_____
_____
_____
_____
_____

3. List any medical conditions that you are currently experiencing:
_____
_____
_____
_____
_____
_____
_

4. Do you smoke cigarettes? YES / NO
If yes, how much? _____

5. Do you drink alcohol? YES / NO
If yes, how many times per week? _____

If yes, on average, how many drinks do you drink per day/event? _____
If yes, have you ever felt the need to cut down on your drinking? _____

6. Have you used illegal medications or drugs? YES / NO
If so, describe the drug(s) and dates you used drug(s):

_____
_____
_____

7. Please indicate on each item below whether you, any of your blood relatives, your spouse/partner, or anyone living with you has experienced any of the following: (who and when)
Problem Drinking _____
Mental Illness _____
Alcoholism _____
Drug Dependence _____
Emotional Problems _____
Depression _____
Psychological or Psychiatric Treatment _____
_____

Suicide Attempts _____
_____

Committed Suicide _____
(who, when?)

8.Have you ever been seriously depressed or felt suicidal? YES / NO
If yes, please describe: _____
_____
_____
_____
_____

9. Who is your primary care physician? _____Phone_____

10. What medication(s) do you currently take? _____
_____
_____
_____
_____
_____
Who prescribed this medication? _____Phone_____

11. Have you sought psychological treatment in the past? YES / NO
If so, please list all psychologists, counselors, psychiatrists, or social workers with whom you have sought treatment.
Name _____
Location _____
Date(s) _____
Type of Service_____

Name _____
Location _____
Date(s) _____
Type of Service_____

Name _____
Location _____
Date(s) _____
Type of Service_____
(add additional information on a separate piece of paper if needed).

12. List any support groups or therapy groups that you have attended.

_____
_____
_____

RELIGIOUS/SPIRITUAL EXPERIENCE:
1. Do you consider yourself a spiritual or religious person? YES / NO
If so, what types of activities do you engage in to meet your spiritual/religious needs?

_____
_____
_____
(Religion/Denomination:_____)

SOCIAL RELATIONSHIPS:
1.
Do you have (please check one): ____ many friends ____ a few “very special” friends
____ seldom make friends ____ usually withdraw / avoid from others

2. Has there recently been a change in the type/number of these relationships?
YES / NO
If so, please describe:

_____
_____

3. Do you have difficulty in social situations (too shy; try too hard to please others, become too "hyper," aggressive, or possessive; fearful/afraid of others)? YES / NO
If so, please describe: _____
_____
_____

4. How do you usually cope with stress?
_____
_____
_____

5. What types of activities do you usually enjoy doing?
_____
_____
_____
_____

6. Briefly describe your strengths and interests:
_____
_____
_____
_____

7 OTHER:
1. Is there anything else that you have not had the opportunity to note on these forms that is important for Dr. Lane to know about you? If yes, please respond below or on the back of this form.
_____
_____
_____
_____
_____

Your signature below indicates that you have responded to this questionnaire as completely and candidly as you are able. Thank you.

Printed Name _____

Signature _____DATE _____