

CEDAR CREEK ASSOCIATES
...private, independent practitioners

ADULT QUESTIONNAIRE

Personal and Family Information

Name _____ Date _____

Date of Birth _____ Social Security Number _____

Present Job _____ Employer _____

Length of time at job _____ Education Level _____

Religion _____ Military service history _____

Approximate family income _____

Marital History

Number of marriages _____ Number of divorces _____

Spouse's Name

Marriage Dates From/To

Names/ages of children

Occupation of spouse _____ Please list everyone else (other than your children) who lives in your home and state the relationship to you:

Your parent's names

Age (Deceased?)

Married or Divorced

Please list your brothers and sisters by first name and give their age. Place yourself in the list.

Physical and Health Information

Physician: _____ Date of last physical exam: _____

List significant illnesses, chronic medical conditions, or injuries with approximate dates:

Have you ever been unconscious from a head injury? _____
If so, when? _____

Please check any item below that you have experienced:

Childhood		Adulthood
_____	Neglect	_____
_____	Physical Abuse	_____
_____	Verbal Abuse	_____
_____	Sexual Abuse	_____
_____	Injury due to Violence	_____
_____	Other Trauma	_____

Have you gained or lost any weight in the last year? _____

Do you have any concerns about your weight? _____

Has anyone in your biological family ever had a nervous breakdown, a mental illness, been depressed, had anxiety problems, attempted or committed suicide? If so, please state the relationship of the person to you and describe the problem he/she had:

Have you ever had previous counseling? _____
If so, with whom (please give approximate dates of service): _____

Social and Recreational Information

How do you spend your leisure time? _____
Please list other hobbies or interest _____

Do you have a close friend or friends _____ How often do you visit, entertain, or go out
with people? _____ Do you exercise? _____ Do you play sports? _____

Is there any reason you cannot exercise? _____

Legal Information

Have you ever been the victim or a crime? _____ Circumstances _____

Have you ever been arrested? _____ Circumstances _____

Are you currently involved in any litigation? _____

Presenting Problem

Please state the reason you are seeking services: _____

What have you done to try and deal with this situation? _____

How would you rate the severity of the problem?
_____ Mildly upsetting _____ Moderately Severe _____ Severe _____ Very Severe

What else would you like your therapist to know? _____

Please check any symptoms you are having:

Tiredness	_____	Sleep difficulties	_____	Sleep too much	_____
Irritability	_____	Worry	_____	Crying	_____
Confusion	_____	Lonely	_____	Withdrawal	_____
Loss of appetite	_____	Overeating	_____	Anxiety	_____
Panic attacks	_____	Thoughts of suicide	_____	Suicide attempt	_____
Too passive	_____	Too aggressive	_____	Conflicts with others	_____
Excessive anger	_____	Excessive sadness	_____	concentration	_____
Decreased sexual desire	_____	Other	_____		

Loss of interest in activities _____
When Did These Symptoms begin? _____

Please check all areas of your life affected by these symptoms:

Work performance	_____	Work relationships	_____	Daily Activities	_____
Social activities	_____	Family relationships	_____	Marriage	_____
School/education	_____	Other	_____		

Please indicate any major changes you have experienced in the past year:

_____ Marriage	_____ Re-marriage	_____ Separation	_____ Divorce	_____ Moved
_____ Illness, injury to self	_____ Illness, injury to other	_____ Financial reversal		
_____ Job change	_____ Loss of job	_____ Death of loved one	Other	_____

Confidentiality

No one will reveal information concerning your counseling to anyone outside this office except as follows: 1) you consent in writing; 2) life or safety is seriously threatened; 3) disclosure is required by law; or 4) you file a benefit claim and the claims payor requires information. In addition, your counselor may consult with professional colleagues as needed for coordination of services, quality assurance, or payment.

I understand and accept these conditions _____
(Signature)

(Date)

**Thank you for providing this information.
Your therapist will be happy to answer questions and address your concerns.**

