7000 Houston Rd building 200 suite #21
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Phone: 859-282-0180 Fax: 859-282-0862

Adult Questionnaire

Name: ______________________________ DOB: ____________ Gender: Male ◯ Female ◯ Other ◯

Reason for seeking treatment/evaluation:
☐ ADHD ☐ Anxiety ☐ Depression ☐ Occupational ☐ Marital ☐ Other
____

Urgency (Why now?):
____
____

Other problems you might be experiencing:

Legal ☐ Financial ☐ School ☐ Victim of Abuse ☐ Other ☐
____
____

Have you sought help for these problems before? ☐ Yes ☐ No
If yes, from whom/when?
____
____

Have you been hospitalized for mental health issues? Yes No If yes, when? ________________________

Where? ____

Have you:
Made a suicide attempt? ☐ Yes ☐ No
Injured yourself on purpose? ☐ Yes ☐ No
Overdosed on purpose or accident? ☐ Yes ☐ No

Have you had recent thoughts about?
Not wanting to live ☐ Yes ☐ No
Hurting yourself ☐ Yes ☐ No
Hurting someone else ☐ Yes ☐ No

Other thoughts worrying you
____
____

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Have you ever had the experience of seeing or hearing things that others are not experiencing

☐ Yes ☐ No

Current/past psychotropic medications

Medication ________________________ Dose __________________

Side Effects____

Started ______________________________ Stopped___________________________

Health Concerns (Please list):

____

____

Childhood

Describe your childhood:

____

____

____

How would you rate your health during your childhood? Good ◯ Fair ◯ Poor ◯

Explain:____

____

Were you ever abused as a child? Yes ◯ No ◯ If so: Physical ◯ Sexual ◯ Emotional ◯

Did anyone in your family suffer from mental illness or substance abuse problems when you were growing up? ☐ Yes ☐ No

Explain:

____

____

Other information about your childhood or family?

____

____

Have you ever been married? ☐ Yes ☐ No How many times? _____ If currently married, how long?

____

If not married, are you in a relationship? ☐ Yes ☐ No

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If in a relationship, how long? ____

Are you currently satisfied with your relationship (married or unmarried)? ☐ Yes ☐ No
If no, explain:
____
____

School History

Highest grade completed? __________

Do you attend school now? ☐ Yes ☐ No If yes, what school?
____

Socially, my school experience was? ◯ Easy ◯ Average ◯ Difficult
____

academically, my school experience was? ◯ Easy ◯ Average ◯ Difficult
____

Work

Do you work? ☐ Yes ☐ No If not, why?
____
____

How many hours per week? _________ How long at this job? _______ Type of job:
____

Substance Abuse

Have you ever used alcohol or other drugs? ☐ Yes ☐ No

If yes: Type of substance _______________________________

Age 1st used how/used_____________________________ usual amount _____________________

How often _______________________________________

Date/last amount used
____

Have you received outpatient/inpatient/residential treatment? ☐ Yes ☐ No

If yes, when? __________________Where? ____

How long? ____

How many times? ______________________________________

Outcome? ____

Legal history

Do you have a legal history? ☐ Yes ☐ No If yes, what charges?
____

Other information

How well are you sleeping? ◯ Good ◯ Fair ◯ Poor
How?____
____

Have you ever witnessed an extremely stressful event? ☐ Yes ☐ No
If yes, explain:
____
____

What are your strengths
____
____

Weaknesses
____
____

Symptoms: CHECK ALL THAT APPLY

ADHD

Inattention
☐ Doesn't seem to listen when spoken to directly ☐ Often doesn't follow directions ☐ Difficulty organizing tasks and activities ☐ Avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort ☐ Forgetful☐ Daydreams ☐ Loses things necessary for tasks/activities ☐ Easily distracted ☐ Often doesn't complete tasks

Hyperactivity/Impulsivity
☐ Fidgets with hands or feet, Leaves seat ☐ Runs about/climbs. ☐ Difficulty playing in activities quietly ☐ On the go. ☐ Talk excessively ☐ Blurt out answers before questions are completed. ☐ Difficulty awaiting turn. ☐ Interrupts/intrudes on others ☐ Leave seat when remaining seated is expected

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Evidence before age seven: ☐ **Yes** ☐ **No**

Depression
☐ Depressed or irritable mood most of day, nearly every day. ☐ Psychomotor agitation/retardation
☐ Diminished pleasure in activities. ☐ Fatigue or loss of energy. ☐ Decrease/increase in appetite.
☐ Feelings of worthlessness/guilt ☐ Insomnia or hypersomnia nearly every day. ☐ Diminished ability to concentrate

Suicidal ideation or attempt ☐ **Yes** ☐ **No**

How long ago? ____________________________ months/years Number of attempts: _________

Anxiety
◯ Unrealistic worry about future events ◯ Unrealistic concern about past behavior ◯ Marked self-consciousness.
◯ Unrealistic concern about competence ◯ Excessive need for reassurance ◯ Marked inability to relax.
How long? ___________________________ months/years

Dysthymia
◯ Depressed or irritable mood most of the day for one year ◯ Low self-esteem ◯ Poor appetite or overeating.
◯ Poor concentration/making decisions ◯ Insomnia/hypersomnia. ◯ Feelings of hopelessness
◯ Low energy/fatigue. (Never without ☐ over 2 months ☐ over one year ☐)
How long? ___________________________ months/years

Other
◯ Stereotyped mannerisms ◯ Overreacts to touch ◯ Odd postures ◯ Compulsive rituals ◯ Obsessive thoughts
◯ Extreme fluctuations in mood high highs or low lows). ◯ Excessive reaction to noise. ◯ Fails to react to loud noises.
◯ Motor tics ◯ Vocal tics ◯ Learning problems
Describe____

◯ Anger If so, what is the result typically _______________________________