PERSPECTIVES THERAPY SERVICES LLC
Adult History and Symptom Questionnaire

Basic background information

First name:_____ M.I. _____ Last name:_____ Today's Date:_____

What type of therapy are you seeking (check all that apply)? ☐ Individual ☐ Couple ☐ Family

Marital status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated

How many times have you been married? _____How long in current marriage?_____

Religious affiliation: _____ Military history: _____

Employment Status: ☐ Full-time ☐ Part-time ☐ Unemployed not looking for work ☐ Unemployed looking for work ☐ Self-employed ☐ Retired

Job title:_____ Company name:_____

Education: Highest Grade Completed _____ Degree:_____ Other:_____

Current concerns

☐ Loss of loved one through death	☐ Separation from loved one	☐ Divorce	☐ Trauma
☐ Care of elders/loved ones	☐ Marriage difficulty	☐ Lifecycle transition	☐ Low self-worth
☐ Change of jobs	☐ Employment concerns	☐ Stress	☐ Abortion
☐ Spouse/significant other conflict	☐ Family conflict	☐ Parenting issues	☐ Co-dependency
☐ Custody issues	☐ Pregnancy	☐ Fertility issues	☐ Victim of emotional abuse
☐ Behavior of adult children	☐ Gender identity	☐ Worry/anxiety interfering with life	☐ Suicidal thoughts
☐ Health problems	☐ Victim of physical abuse	☐ Financial problems	☐ Suicidal behaviors
☐ Substance abuse	☐ Gambling	☐ Eating disorder	☐ Phobia (specific fear)
☐ Excessive computer/electronics use	☐ Sexual orientation exploration	☐ Sexual assault/rape	☐ Legal problems
☐ Pornography seeking behaviors	☐ Violent/abusive behavior	☐ Residual childhood experiences	☐ Employment problems
☐ Interpersonal problems	☐ Unhappy, feeling depressed	☐ School problems	☐ Other:_____

Symptoms

☐ nervousness	☐ dizziness/headaches	☐ fainting spells	☐ heart palpitations	☐ stomach trouble
☐ anxiety	☐ bowel disturbances	☐ nightmares	☐ feel tense	☐ tremors
☐ unable to relax	☐ shy with people	☐ sleep difficulties	☐ overambitious	☐ unmotivated
☐ uneasy in social situations	☐ inferiority feelings	☐ can't keep a job	☐ lonely	☐ impulsivity
☐ excessive sweating	☐ difficulty making decisions	☐ wanting to run away	☐ persistent worrying	☐ indecisiveness
☐ weight loss (_____ lbs.)	☐ weight gain (_____ lbs.)	☐ panic attacks	☐ memory problems	☐ loss of interest in activities
☐ difficulty concentrating	☐ withdrawn/avoid others	☐ decreased energy	☐ drink too much alcohol	☐ irritability
☐ quick to anger	☐ overeat/binge	☐ restrict food	☐ self-harm behaviors	☐ suicidal thoughts
☐ abuse recreational drugs	☐ abuse prescription meds	☐ crying episodes	☐ exercise excessively	☐ mood swings
☐ loss of interest in sex	☐ pornography addiction	☐ negative body image	☐ poor boundary setting	☐ racing thoughts
☐ obsessive thoughts	☐ inattention	☐ lack of focus	☐ lack of motivation	☐ easily distracted
☐ self-critical	☐ poor work performance	☐ teeth grinding	☐ aggressive behaviors	☐ fatigue

Other: ☐_____ ☐_____ ☐_____ ☐_____

Self-care

Check all the following areas of support that you use:
☐ Nuclear family ☐ Church/mosque/temple ☐ Spouse/intimate partner ☐ Extended family ☐ Group of friends ☐ 12-step or similar program ☐ Service system ☐ Close friend

Specifically what do you do (indicate now or in the past) to take care of yourself:

☐ Plenty of sleep ☐ Balanced nutrition ☐ Watch television or movies ☐ Use social media
☐ Meditate ☐ Pray ☐ Exercise/Movement (yoga) ☐ Engage socially
☐ Journal/write ☐ Listen to or play music ☐ Positive self-talk (affirmations) ☐ Artistic expression (draw, paint)
☐ Take time to laugh ☐ Block out time for self ☐ Go to therapy ☺ ☐ Read What else?: ☐ _____

Strengths

☐ bright ☐ insightful ☐ motivated ☐ good leader ☐ optimistic
☐ able to self-regulate emotions ☐ have friends ☐ can calm myself ☐ resourceful ☐ responsible
☐ can ask for help ☐ keep my boundaries ☐ morally ethical ☐ can solve problems ☐ grateful
☐ able to forgive ☐ can express feelings ☐ financially wise ☐ brave/courageous ☐ hopeful
☐ sense of humor ☐ compassionate/kind ☐ patient ☐ good listener ☐ open-minded
☐ stable employment ☐ able to say "no" ☐ active ☐ creative ☐ willing to try new attitudes & behaviors ☐ persistent

Medical/Psychiatric History

Please check any illness you currently have or have had in the past:

☐ Diabetes ☐ High/Low Blood Pressure ☐ Lung Disease ☐ Heart Disease ☐ Low Blood Pressure
☐ Asthma ☐ Cancer ☐ Any Sexually Transmitted Illness ☐ Arthritis ☐ Substance Abuse
☐ Seizures ☐ Traumatic Brain Injury ☐ Migraines ☐ Thyroid Disease ☐ AIDS/HIV
☐ Depression ☐ Auto-Immune Disorders ☐ Cirrhosis ☐ Muscular Disorder ☐ Nerve Disorder
☐ Bi-polar Disorder ☐ Personality Disorder ☐ Anxiety Disorder ☐ Attention Deficit Disorder ☐ Psychotic Disorder (such as schizophrenia)
☐ Ulcer ☐ Colitis/IBS ☐ Learning Disorder ☐ Eating Disorder ☐ Other (please describe) _____

Which relatives have experienced any mental health or substance abuse related problems?

_____ _____
Family member/relationship to you — Psychiatric concern/diagnosis

_____ _____
Family member/relationship to you — Psychiatric concern/diagnosis

_____ _____
Family member/relationship to you — Psychiatric concern/diagnosis

Is there anything else you would like me to know about your medical history?

_____

Risk Assessment

Caffeine consumption: What is your typical caffeinated drinks of choice? (circle one) Coffee Tea Soda _____ ounces/day

Nicotine use: Do you currently smoke cigarettes? ☐ Yes ☐ No **Recreation drug use?** ☐ Yes ☐ No

Alcohol consumption: What is your typical drink of choice? (circle one) Beer Wine Liquor
Estimated daily or weekly consumption: _____ cans/bottles/glasses,ounces/**day** or _____ cans/bottles/glasses,ounces/**week**

Are you currently having suicidal thoughts? ☐ Yes ☐ No

Have you ever made a suicide attempt? ☐ Yes ☐ No If yes, when and how?_____

Has anyone close to you made a suicide attempt? ☐ Yes ☐ No Has anyone close to you completed suicide? ☐ Yes ☐ No