

# MEQUON CLINICAL ASSOCIATES, SC

## ADULT HISTORY

INSTRUCTIONS: Your therapist would like you to answer these questions. This will help him or her better understand your situation.

Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

In case of an emergency, please give the name and telephone number of your nearest relative:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### PSYCHOLOGICAL HISTORY

**What problem(s) caused you to come to therapy at Mequon Clinical Associates?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did problem begin? \_\_\_\_\_

Has the problem been constant since its beginning? Yes \_\_\_ No \_\_\_

What is the worst symptom you've had? \_\_\_\_\_

Is problem ever absent? Yes \_\_\_ No \_\_\_ If yes, when? \_\_\_\_\_

Who made the decision to come to therapy? \_\_\_\_\_

**Check if you have had any of these problems or symptoms lately:**

- |                                      |   |  |   |
|--------------------------------------|---|--|---|
| <input type="checkbox"/> Anxiety     | <input type="checkbox"/> Changes/problems in eating           | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Loss of hope       |
| <input type="checkbox"/> Tearfulness | <input type="checkbox"/> Changes/problems in sleeping         | <input type="checkbox"/> Fatigue/tiredness   | <input type="checkbox"/> Excessive worry    |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Chronic Pain                         | <input type="checkbox"/> Sexual difficulties | <input type="checkbox"/> Impulsive behavior |
| <input type="checkbox"/> Depression  | <input type="checkbox"/> Difficulty concentrating             | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Violent behavior   |
| <input type="checkbox"/> Fears       | <input type="checkbox"/> Loss of interest in usual activities | <input type="checkbox"/> Other _____         |   |

**Have there been any recent illnesses or deaths among your family or close friends?** \_\_\_ Yes \_\_\_ No  
Explain: \_\_\_\_\_

**Have there been any recent major losses among your family or close friends?** \_\_\_ Yes \_\_\_ No  
Explain: \_\_\_\_\_

**Have there been any recent crises or major changes in your life?** \_\_\_ Yes \_\_\_ No  
Explain: \_\_\_\_\_

**Have you ever intentionally hurt yourself or made a suicide attempt?** \_\_\_ Yes \_\_\_ No  
Explain: \_\_\_\_\_

**Have you ever taken medication for anxiety, depression, sleep, or other emotional conditions?** \_\_\_ Yes \_\_\_ No  
Explain: \_\_\_\_\_

**Have you been in counseling or psychotherapy before?** \_\_\_ Yes \_\_\_ No  
If so, for what issues? \_\_\_\_\_  
What was the therapist's name and when did this occur? \_\_\_\_\_

**Have you had any hospitalizations for emotional problems?** \_\_\_ Yes \_\_\_ No  
Explain: \_\_\_\_\_

**Please name any people or organizations who you feel provide help and support to you.** \_\_\_\_\_  
\_\_\_\_\_

## MEDICAL HISTORY

List any current medical conditions and disabilities: \_\_\_\_\_  
 \_\_\_\_\_

Are you taking any medications?  Yes  No

If yes, list current medications and daily dosages: \_\_\_\_\_  
 \_\_\_\_\_

List past medical conditions (include surgeries): \_\_\_\_\_  
 \_\_\_\_\_

Name of your physician(s) and telephone numbers & addresses: \_\_\_\_\_  
 \_\_\_\_\_

Have you had a medical exam within the past year?  Yes  No

List any significant findings: \_\_\_\_\_

## DRUG AND ALCOHOL USE

Please describe the drug and alcohol use of your family. Use the number which best states how often each person uses each drug. For your children, please write in the name of the child at the top of the column.

0 = Never; 1 = less than once a month; 2 = 1-4 days a month; 3 = almost daily; 4 = daily; 5 = used in past, not using now

<u>SUBSTANCE</u>	<u>SELF</u>	<u>PARTNER/SPOUSE</u>	<u>CHILD</u>	<u>CHILD</u>	<u>YOUR PARENTS</u>
Caffeine	___	___	___	___	___
Nicotine	___	___	___	___	___
Beer/Wine/Liquor	___	___	___	___	___
LSD	___	___	___	___	___
Marijuana	___	___	___	___	___
Inhalants	___	___	___	___	___
Sedatives	___	___	___	___	___
Amphetamines	___	___	___	___	___
Cocaine/Crack	___	___	___	___	___
Others (specify)	___	___	___	___	___

Are you concerned about your drug or alcohol use?  Yes  No  
 Is someone who cares about you concerned about your use of drugs or alcohol?  Yes  No  
 Do you ever feel guilty about your use of drugs or alcohol?  Yes  No  
 Are you concerned about the drug or alcohol use of someone in your family?  Yes  No  
 Did you grow up in a home in which a parent abused drugs or alcohol?  Yes  No  
 Has anyone in your family been in treatment for drug or alcohol abuse?  Yes  No  
 If yes, list who and for what treatment: \_\_\_\_\_

## FINANCIAL / LEGAL HISTORY

Do you have serious financial concerns?  Yes  No  
 If yes, explain: \_\_\_\_\_  
 Have you ever been arrested?  Yes  No  
 If yes, explain: \_\_\_\_\_  
 Have you ever been involved with Protective Services?  Yes  No  
 If yes, explain: \_\_\_\_\_

## SCHOOL, MILITARY & WORK HISTORY

Are you currently enrolled in school?  Yes  No  
 If yes, what is field of study? \_\_\_\_\_  
 What is your highest grade completed? \_\_\_\_\_  
 Have you served in the Military?  Yes  No  
 If yes, which branch? \_\_\_\_\_ When? \_\_\_\_\_ Overseas? \_\_\_\_\_ Combat? \_\_\_\_\_  
 What is your occupation? \_\_\_\_\_  
 Are you currently employed?  Yes  No What is length of time at current job? \_\_\_\_\_  
 If not employed, how long were you employed at last job held? \_\_\_\_\_