Robyn Claar, Ph.D., PLLC

Adult Questionnaire

Name: Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_/ /

Address:

City: State/Province: Zip/Postal Code:

Email Address:

Telephone:

How did you learn of my practice? (check all that apply)

 I was referred by a provider (which provider?)

 A friend, family member or acquaintance recommended it

 I saw the practice website

 Other (explain)

Please give the reason for today’s evaluation/appointment:

Family Information:

Marital Status:

□ Married: How long? □ Separated How long?

□ Divorced: How long? □ Widow How long?\_\_\_\_\_\_\_\_\_\_\_

□ Single

Please describe previous marriage(s), if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have children? □Yes □No If so, how many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If divorced who has custody? □ Mother □ Father □ Joint Custody

□ Neither Specify:

Are any of your children adopted? □ Yes □ No

If yes, please describe the circumstances of the adoption: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you lost a child? □ Yes □ No

Do any of your children have special needs? □ Yes □ No

If so, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list all children and other adults living in your home:

Name Age Relationship

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

Do you have a history of violence in your house or in your relationships? □ Yes □ No

Is anyone that you are in a close relationship with abusing drugs and/or alcohol? □ Yes □ No

Please describe the circumstances of any of the above if marked yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Work Information:

Are you currently employed? □ Yes □ No Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: How long with this employer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe your current level of job satisfaction?

□ Very Satisfied □ Satisfied □ Average □ Dissatisfied □ Very Dissatisfied

If you are not currently employed, which of the following describes you?(check all that apply)

□ Student □ Retired □ Looking for work □ Stay-at-home parent

□ Caring for sick/elderly relative □ Volunteer □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Education History:

If you are currently a student:

Name of School: Year:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Performance: □ Poor □ Fair □ Good

Highest degree completed to date: □ High School □ College □ Graduate/professional

□ Technical Training □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any known learning disabilities/attention problems? □ Yes □ No

 If Yes, when were you diagnosed and explain specific disabilities (Please provide copies of testing if possible) :

Therapy History:

Have you ever received mental health related therapy? □ Yes □ No

Have you received Cognitive Behavioral Therapy (CBT)? □ Yes □ No □ Don’t know

How would you describe the effectiveness of this treatment?

 □ Much improvement □ Some improvement □ No improvement

Please describe any interventions you have previously received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever taken psychiatric medication? □ Yes □ No

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| --- | --- | --- | --- | --- | --- |
| Medication | Dosage | Dates of Use | Prescriber | Benefits | Side Effects |
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Family Medical/Psychiatric History:

Do medical illnesses run in the family? (example: seizures, thyroid problems, allergies) □ Yes □ No

If yes, please describe, specifying relationship to you and including treatment:

Have any of your biological relatives had psychiatric problems? □ Yes □ No □ Don’t know

(Please note any that apply: Major Depression, Bipolar Disorder, Obsessive-Compulsive Disorder, Tic Disorders, other Anxiety Disorders, Schizophrenia, Substance Abuse, Suicide Attempts, other Psychiatric problems.)

If yes, which biological relatives(s)? □ Mother □ Father □ Brother □ Sister

□ Grandmother (maternal/paternal) □ Grandfather (maternal/paternal)

□ Aunt (maternal/paternal) □ Uncle (maternal/paternal)

□ Other (Specify: )

If yes, please describe problem(s), including treatment:

Outside of biological relatives, are there any other people with whom you have significant contact who have psychiatric problems? □ Yes □ No □ Don’t know

If yes, please specify the contact(s) and describe the problem(s), including treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health:

Please list any significant childhood illnesses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please list any surgery and when it was performed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever had a seizure, head trauma, or loss of consciousness? □ Yes □ No

If so, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been hospitalized? □ Yes □ No

If so, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been seen in the emergency room? □ Yes □ No

If so, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you currently receiving treatment for a medical condition? □ Yes □ No

If so, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Medication | Dosage | Dates of Use | Prescriber |
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Is your vision within normal limits? □ Yes □ No

Is your hearing within normal limits? □ Yes □ No

Do you smoke? □ Yes □ No If yes, how many a day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you engage in regular exercise/physical activity? □ Yes □ No

Are you happy with your current weight/level of fitness? □ Yes □ No

 If no, why not?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you drink alcohol? □ Never □ Monthly □Weekly □ Daily

Do you regularly use street drugs? □ Yes □ No

Do you consider yourself dependent on drugs and/or alcohol? □ Yes □ No

Describe your sleep: □ Excessive □ restless □ Insomnia □ Fatigued □ No Difficulties