**Jane Ridgway, MA, LPC, NCC**
Phone 214.662.7337


1701 Gateway Blvd. E. Ste.385
Richardson, TX 75080

# Comprehensive Adult Questionnaire

Name: _____ Date: _____

**Presenting Problem**

What are the main problems or symptoms that caused you to seek help now?

_____
_____
_____

Describe any stresses in your life that may have contributed to the problem:

_____
_____
_____

Describe the history of the problem from its onset until now:

_____
_____
_____

Have you had a similar problem in the past? __ Yes __ No If so, please describe the episodes and the dates they occurred.

_____
_____
_____

Were you treated for this problem? __Yes __No If so, please describe the treatment you received.

_____
_____

Has this problem caused you to experience any decrease in your ability to function in the following areas? If so, please describe:

School performance: _____

Work performance: _____

Relationship with spouse/significant other: _____

Functioning as a parent: _____

Social life: _____

Ability to manage chores at home: _____

**Jane Ridgway, MA, LPC, NCC**
Phone 214.662.7337


1701 Gateway Blvd. E. Ste.385
Richardson, TX 75080

**Medical History**

Please list all medications you are currently taking:

Prescription Medication Dose Start Date (MMYY)

_____
_____
_____
_____
_____

Please list any health problems:

_____
_____
_____

**Mental Health History**:

Please list any Psychiatrist/Psychologist/Therapist you have seen previously:

Name Dates Seen Reason Medications Prescribed

_____
_____
_____
_____
_____

Have you ever attempted suicide? __Yes __No If yes, please describe the nature of the event and the date(s) of occurrence.

_____
_____

Please list any blood relatives who have any history of mental or emotional problems (e.g. depression, manic depression, alcoholism, drug abuse, suicide, schizophrenia, anxiety problems, eating disorders, Attention Deficit Disorder, etc.)

Relative Problem

_____
_____
_____

**Jane Ridgway, MA, LPC, NCC**
Phone 214.662.7337


1701 Gateway Blvd. E. Ste.385
Richardson, TX 75080

**Substance Use**:

Do you use any of the following?

| Substance | Yes | No | Amount | Frequency: Daily | Weekly | Date last used |
|---|---|---|---|---|---|---|
| Tobacco | __ | __ | _____ | ___ | ___ | _____ |
| Caffeine | __ | __ | _____ | ___ | ___ | _____ _ |
| Alcohol | __ | __ | _____ | ___ | ___ | ____ _____ |
| Marijuana | __ | __ | _____ | ___ | ___ | _____ _ |
| Cocaine | __ | __ | _____ | ___ | _ __ | _____ |
| Amphetamines | __ | __ | _____ | ___ | __ _ | __ _____ |
| LSD | __ | __ | _____ | ___ | ___ | _____ |
| Heroin | __ | __ | _____ | ___ | ___ | _____ |
| Pain Killers | __ | __ | _____ | ___ | ___ | _____ |
| IV Drug Use | __ | __ | _____ | ___ | ___ | _____ |

Have you ever felt that you were abusing drugs or alcohol? __ Yes __No If so, please describe:
When Nature of the Problem.

_____

_____

Have you tried to stop drinking? __ Yes __ No If yes, what was the outcome?

_____

_____

Have you ever attended AA? __ Past __ Current If yes, do you have a sponsor and how often do you attend meetings?

_____

Have you ever attended NA? __ Past __ Current If yes, do you have a sponsor and how often do you attend meetings?

_____

**Family/Social History**

Where were you born and raised?

_____

Please list your siblings and their current ages:

_____

**Jane Ridgway, MA, LPC, NCC**
Phone 214.662.7337


1701 Gateway Blvd. E. Ste.385
Richardson, TX 75080

Are you close to your siblings?

_____

How would you describe your relationship with your father?

_____

_____

How would you describe your relationship with your mother?

_____

_____

Describe your childhood:

_____

_____

Were your parents divorced? __ Yes __ No If yes, how old were you? _____
With whom did you live after the divorce? _____
Did your mother remarry? __ Yes __ No Did your father remarry? __ Yes __ No
What was your relationship like with the stepparent(s)?

_____

_____

Were you ever subjected to any type of abuse (emotional, physical, sexual)? __ Yes __ No
If yes, please describe the events and ages the abuse occurred.

_____

_____

Have you lost a close family member or friend? __Yes __ No

Who? _____ When? _____

**Educational History**

Did you complete high school? __Yes __ No

What kind of grades did you receive in school? _____

How did you get along with your peers? _____

How did you get along with your teachers? _____

Did you attend college? __Yes __ No

Where? _____
Degree? _____ _____

**Jane Ridgway, MA, LPC, NCC**
Phone 214.662.7337


1701 Gateway Blvd. E. Ste.385
Richardson, TX 75080

**Occupational History**

Are you currently working? __Yes __ No
What is your occupation? _____
What is your current position? _____
Where do you work? _____ How long have you been there? _____
Are you satisfied with your job? __Yes __ No If no, explain:

_____

Describe any current job stresses you may be experiencing:

_____

_____

How well do you get along with your co-workers? _____
How well do you get along with your supervisors? _____
List your last two jobs and how long you worked there:

_____

_____

**Relationship History**

Are you currently __ Single __ Married __ Divorced __ Widowed __ Living Together
How long? _____
What is your sexual orientation? _____
Describe your relationship with your spouse or significant other:

_____

_____

_____

List any stresses or problems in your relationship:

_____

_____

If married, what is your spouse's occupation? _____
Have you been married before (or in a long-term committed relationship)? __Yes __ No
How many times? _____ How long did these relationships last? _____
Please describe the reason for the break-up or divorce:

_____

If you have children, what are their names and ages?

_____

_____

Describe any problems you may be experiencing with your children:

**Jane Ridgway, MA, LPC, NCC**
Phone 214.662.7337


1701 Gateway Blvd. E. Ste.385
Richardson, TX 75080

**Spirituality**

What is your religious preference?

How often do you attend religious services? _____ Where? _____

**Other Information**

Any hobbies?

Is there any other important information about you that has not been covered, which you feel the therapist should know?

*****Please complete the attached symptom checklist*****

**Jane Ridgway, MA, LPC, NCC**
Phone 214.662.7337


1701 Gateway Blvd. E. Ste.385
Richardson, TX 75080

**Symptom Checklist**

Check all that apply. Then circle items that are especially bothersome to you.

**Recent Past**

1. Please check any of the following which may have been particularly stressful to you:
   ___ ___ Job related stress
   ___ ___ Marital conflict
   ___ ___ Death or loss of loved one
   ___ ___ Move to a new place and losing contact with friends or family
   ___ ___ Conflict with children
   ___ ___Children with behavior problems
   ___ ___ Conflict with parents or extended family
   ___ ___ Feeling stress due to recalling memories of trauma or stress in my life
   ___ ___ Family member with an alcohol or drug problem
   ___ ___ Being abused by someone
   ___ ___ Financial pressure
2. Any of the following symptoms for most of the day, nearly every day, for periods longer than several days at a time:
   ___ ___ Depressed or sad mood
   ___ ___ Loss of interest or pleasure in things I'm normally interested in
   ___ ___ Difficulty falling asleep
   ___ ___ Difficulty staying asleep or waking up too early (Average number of hours you are sleeping per night? _____)
   ___ ___ Sleeping too much
   ___ ___ Increased appetite/weight gain (lbs._____)
   ___ ___ Decreased appetite/weight loss (lbs. _____)
   ___ ___ Fatigue/Poor energy level
   ___ ___ Decreased activity (work, social, physical, sexual)
   ___ ___ Poor concentration or slowed thinking
   ___ ___ Thoughts of suicide
   ___ ___ Excessive feelings of guilt or worthlessness
   ___ ___ Decreased sex drive or interest
3. Any of the following symptoms, more days than not, for months at a time:
   ___ ___ Excessive anxiety or worry for no good reason
   ___ ___ Trembling, twitching or feeling "shaky"

**Jane Ridgway, MA, LPC, NCC**
Phone 214.662.7337


1701 Gateway Blvd. E. Ste.385
Richardson, TX 75080

**Recent Past**

___ ___ Muscle tension or muscle aches
___ ___ Easily fatigued
___ ___ Dry mouth
___ ___ Dizziness or lightheadedness
___ ___ Nausea, diarrhea or other stomach problems
___ ___ Frequent urination
___ ___ Feeling keyed up or on edge
___ ___ Irritability
___ ___ Trouble falling or staying asleep

4. Panic attacks (any period of extreme, increased anxiety lasting from a few minutes up to several hours) with any of the following symptoms:
___ ___ Panic attacks/anxiety attacks
___ ___ Persistent worry that I will have a panic attack
___ ___ Heart pounding or racing heart
___ ___ Trembling or shaking
___ ___ Sweating
___ ___ Choking
___ ___ Nausea or stomach problems
___ ___ Feelings of unreality
___ ___ Numbness or tingling sensations
___ ___ Feeling of smothering or shortness of breathe
___ ___ Fear of dying
___ ___ Fear of going crazy or doing something uncontrolled
___ ___ Chest pain or discomfort
___ ___ Dizziness, unsteady feelings or faintness
___ ___ Flushes, hot flashes or chills
___ ___ Avoiding situations or places that may cause panic or severe anxiety
5. Any of the following symptoms for most of the day, nearly every day, for more than four days at a time:
___ ___ Euphoric or "high" mood
___ ___ Irritable mood
___ ___ Decreased need for sleep without feeling tired
___ ___ Increased energy level
___ ___ Increased activity (work, social, physical, sexual
) ___ ___ Thoughts speeded up or racing thoughts
___ ___ Increased talkativeness or being much more socially outgoing

**Jane Ridgway, MA, LPC, NCC**
Phone 214.662.7337


1701 Gateway Blvd. E. Ste.385
Richardson, TX 75080

**Recent Past**

___ ___ Making decisions too impulsively
___ ___ Going on spending sprees

6. Check any of the following relating to your alcohol or drug use:
___ ___ I've felt alcohol or drugs were causing a problem for me
___ ___ I have felt guilty about my use
___ ___ Others have annoyed me about my use
___ ___ I have had a desire (or made unsuccessful efforts) to cut down or control my use
___ ___ I've tried unsuccessfully to control my use
___ ___ I've used alcohol or drugs more often or in larger amounts than I intended
___ ___ I've had to increase my use of alcohol or drugs to get the desired effect
___ ___ I've had problems with withdrawal (shakes, nervousness, insomnia, etc.)
___ ___I've cut down or stopped using alcohol or drugs
___ ___ I've been to a meeting of Alcoholics Anonymous or Narcotics Anonymous
7. Any of the following disturbances in eating or maintaining normal weight:
___ ___ Insistence on maintaining body weight below expected for age and height
___ ___ I feel "fat" even when others see me as underweight
___ ___ Eating binges
___ ___ Feeling of lack of control of eating during eating binges
___ ___ Vomiting or using laxatives to prevent weight gain
___ ___ Being over-concerned about body weight and shape
8. Check any of the following that apply:
___ ___ I tend to do things on impulse which end up being damaging to me or others
___ ___ I have mood swings (depression, irritability, anger) lasting up to several hours
___ ___ I have tried to commit suicide
___ ___ I have made cuts, burns or other injuries to myself without wanting to kill myself
___ ___ My relationships always seem to work out wrong
___ ___ My mood often shifts from being either overconfident to having low self esteem
___ ___ I have a hard time sympathizing with other's pain
___ ___ I often feel others do not understand me
___ ___ I tend to get very hurt or angry when I am criticized or rejected by someone
___ ___ I tend to need a lot of reassurance or approval from others
___ ___ I am very concerned about my appearance
___ ___ Others often expect too much of me
9. Any of the following at any time:
___ ___ Vivid voices in my head that do not seem like my ideas
___ ___ Feeling that others might be putting thoughts in my head

**Jane Ridgway, MA, LPC, NCC**
Phone 214.662.7337


1701 Gateway Blvd. E. Ste.385
Richardson, TX 75080

**Recent Past**

___ ___ Feeling others might be able to read my thoughts
___ ___ Others feel I am too suspicious or paranoid
___ ___ Feeling others might be talking about me

10. Any of the following problems relating to a past severe trauma or stress:
___ ___ I have had an experience that was so traumatic that nearly anyone would have been seriously stressed by it
___ ___ History of relatives hurting me physically or touching me in sexual areas
___ ___ History of unwanted sexual contact
___ ___ I have memories or dreams of a stressful event that I have trouble putting out of my head
___ ___ I sometimes have flashbacks of past events; or I act or feel as though I am re-living a stressful event from the past
___ ___ I try to avoid situations or people that remind me of a stressful event in the past
11. Any of the following obsessions or compulsions:
___ ___ Excessive doubting; or repeated, forced unreasonable thoughts, images, or sounds that I cannot get out of my mind
___ ___ Urges to check things, wash things, or count repeatedly
___ ___ Excessive concern about coming into contact with germs or dirt
___ ___ Excessive concern with right/wrong or morality
___ ___ Excessive need for things to be exact or symmetrical

**Thank you!**