DARING MINDS
therapy

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Adult Pre-treatment Questionnaire:

Today's Date: _____

Name: _____ Date of Birth: _____

Gender: _____

Ethnic / Racial Identity or Heritage (circle all that apply):

Native American Hispanic/Latino Native Hawaiian/Pacific Highlander
Asian/ Asian American White Black/African American

What is your culture? _____

Where were you born? _____ Where were you primarily raised? _____

How long have you lived at the address you provided? _____

Do you rent or own? _____

Are you spiritual? No Yes

If so, how? _____

Relationship Status (circle all that apply):

In a relationship Single Engaged Married
Separated Divorced Widow (er)

Presenting Problem – Please describe below the reason you are seek therapy/evaluation at this time:

_____

_____

_____

Medical History:

Please rate your physical health as: poor fair good excellent

Have you had/currently have any of the following (circle all that apply):

Asthma	visual impairment	obesity
Diabetes	hearing impairment	miscarriage / stillbirth
Ulcers	physical disability	menstrual problems
Blood pressure problems	seizures	fertility problems
Heart condition	migraines/headaches	difficult pregnancies
High cholesterol	head injury	abortion
Stomach/bowel problems	chronic pain	cancer
Thyroid problems	arthritis	allergies
Fibromyalgia	sexually transmitted disease	
Other, please specify:		

If you circled any of the above medical items, please explain:

Please list any significant accidents, surgeries, illnesses, or hospitalizations:

When was your last hospitalization? _____

What was it for? _____

Medications, supplements, or Herbs:

Medication/Supplement Name	Dosage	Prescribed by	Purpose

Do you have any allergies? No Yes

If so, what are you allergic to? _____

Who is your primary care physician? _____

When was your last physical examination? _____

Any family history of the following? (Please circle all that apply.)

Asthma	visual impairment	obesity
Diabetes	hearing impairment	miscarriage / stillbirth
Ulcers	physical disability	menstrual problems
Blood pressure problems	seizures	fertility problems
Heart condition	migraines/headaches	difficult pregnancies
High cholesterol	head injury	abortion
Stomach/bowel problems	chronic pain	cancer
Thyroid problems	arthritis	allergies
Fibromyalgia	sexually transmitted disease	
Other, please specify:		

If you circled any of the above medical items, please explain:

Educational History:

Highest degree completed: less than 12 years high school college graduate degree
Are you currently a student? No Yes

Past/ present school information:

Name of school/s (including high school):_____

Major/s: _____

Employment (circle all that apply):

employed and satisfied	employed and dissatisfied
unemployed, looking for work	conflicts at work
Unemployed, not looking for work	disabled

If you are currently employed, where are you working? _____

Do you have any current financial problems? No Yes

If yes, explain: _____

Do you receive any money from any of the following sources: No Yes

If yes, please provide monthly amount:

_____ friends / family	_____ food stamps	_____unemployment
_____ child support	_____ welfare	_____illegal sources
_____ SSI / Disability	_____ Retirement	

How many people depend on you for the majority of their food, housing, etc.? _____

Military Service:

Have you been / are you now in the military? No Yes – dates: _____

If yes, which branch? _____

Have you ever been deployed? No Yes

If yes, were you in combat? No Yes – when/where? _____

If discharged, what type of discharge did you have? _____

Discharge date: _____

Alcohol / drug history

Please list age of first use and age of last use for the following substances:

Substances:	First Use:	Last Use:	Frequency:	Quantity:
Tobacco				
Alcohol				
Marijuana				
Cocaine / crack				
Methamphetamine				
Hallucinogens				
Opiates				

What is your drug of choice? _____

Have you ever been voluntarily abstinent form your drug of choice? _____

When? _____ How long? _____

Have you ever had any counseling or treatment for substance abuse? No Yes

If yes, please list when, where, and what type of treatment: _____

Have you ever used a needle to administer drugs? No Yes

If yes, when was the last time? _____

Have you ever overdosed on drugs? No Yes

If yes, how many times? _____ when was the last time? _____

How much money have you spent in the last thirty days on: $ _____ alcohol $_____ drugs

Legal history:
Do you have a legal history consisting of past or current if yes, please provide an explanation:

Arrests no yes Explain: _____

Restraining order no yes Explain: _____

Divorce / Custody no yes Explain: _____

Incarceration no yes Explain: _____

Probation no yes Explain: _____

Are you currently involved with DHHS? No Yes
If yes, please explain (include the name of your caseworker):

Family History:

Please list parents, siblings, spouse/partner, children and significant relatives/others:

Name (First and Last)	Relationship	Age	School / Occupation	City of Residence

How many pregnancies have you experienced? _____ Are you current pregnant? No Yes

Number of marriages: _____ if married, how long? _____

Who currently lives in your household?

Has anyone in your family experienced any of the following (check all that apply):

Family History	ADHD	Anxiety	Bipolar Disorder	Depression	Schizophrenia	Trauma History	Abusive Behavior	Drug Abuse	Alcohol Abuse
Mother									
Father									
Sister									
Brother									
Maternal Uncle									
Paternal Uncle									
Maternal Aunt									
Paternal Aunt									
Maternal Grandmother									
Paternal Grandmother									
Maternal Grandfather									
Paternal Grandfather									
Biological Child									

Have you ever experienced any domestic violence, emotional, physical, or sexual abuse? No Yes

If yes, please explain:

Have you ever been the perpetrator of abuse? No Yes

If yes, please explain:

Symptom checklist

The following is a list of symptoms that have to do with various psychological problems. Please circle the number from zero (0) to four (4) that best describes how much this symptom or problem bothers you. Use the following scale:

0 = not at all 1 = a little bit 2 = moderately 3 = quite a bit 4 = extremely

In the <u>past week</u>, how much were you bothered by: Not at all			**Moderately**		**Extremely**
1. Feeling depressed, sad, blue, down, unhappy most of the time	0	1	2	3	4
2. Feeling easily annoyed or irritated	0	1	2	3	4
3. Feeling no interest in things or avoiding enjoyable activities, family or friends	0	1	2	3	4
4. Feeling tired all the time even with adequate sleep	0	1	2	3	4
5. Trouble concentrating can't stay focused on activities	0	1	2	3	4
6. Feeling lonely even when you are with people	0	1	2	3	4
7. Feeling helpless about the future	0	1	2	3	4
8. Significant increase or decrease in appetite or weight	0	1	2	3	4
9. Sleeping problems: can't fall sleep, restless sleep, sleeping too much	0	1	2	3	4
10. Thoughts of suicide: thinking "I wish I were dead," "life isn't worth living anymore"	0	1	2	3	4
11. Suicide attempt: intent or action to hurt or kill self with pills, weapons, etc.	0	1	2	3	4
12. Racing thoughts, rapid speech, little or no need for sleep, impulsive traveling and/or spending money recklessly	0	1	2	3	4
13. Doing things without thinking and often getting yourself in a jam	0	1	2	3	4
14. Feeling so restless you could not sit still	0	1	2	3	4
15. Feeling anxious: worrying excessively or worry about many things	0	1	2	3	4
16. Feeling tense or keyed up	0	1	2	3	4
17. Spells of terror or panic	0	1	2	3	4
18. Fearful feelings or being humiliated in social situations	0	1	2	3	4
19. Feeling uneasy in crowds or in open spaces	0	1	2	3	4
20. Feeling afraid to travel on buses, subways, trains, or planes	0	1	2	3	4
21. Feeling inferior to others	0	1	2	3	4
22. Having to avoid certain things, places or activities because they frighten you	0	1	2	3	4
23. Sudden re-experiencing of feelings, thoughts, images of a traumatic event	0	1	2	3	4
24. Temper outburst that you could not control	0	1	2	3	4
25. Feeling "nothing" or numb, as if blocked as in taking a pain killer	0	1	2	3	4
26. Excessive repeating	0	1	2	3	4
27. Excessive repeating of an activity that you couldn't resist even though it sometimes seems foolish (e.g. cleaning, washing hands, counting, etc.)	0	1	2	3	4
28. Feeling that you are watched or talked about by others	0	1	2	3	4
29. Seeing or hearing things outside yourself that others tell you are not really there	0	1	2	3	4
30. The idea that someone else can control your thoughts	0	1	2	3	4
31. Feeling that most people cannot be trusted	0	1	2	3	4

32. Persistent fears about health problems despite doctors finding nothing wrong	0	1	2	3	4
33. Episodes of binge eating purging/vomiting, or periods of not eating	0	1	2	3	4
34. Feeling others are to blame for most of your troubles	0	1	2	3	4
35. Having urges to break or smash things or injure someone	0	1	2	3	4
36. Getting into frequent arguments with friends, family, or coworkers	0	1	2	3	4
37. Difficulty managing children, feel parenting skills are deficient	0	1	2	3	4
38. Occupational concerns, job dissatisfaction, problems with employer/coworkers	0	1	2	3	4
39. Other:	0	1	2	3	4

Psychological history:

Have you ever taken medication for psychological problems/concerns? No Yes

If so, what have you taken?

Are you currently taking any medications? No Yes

If so, what are you currently taking?

Do you have a psychiatrist? No Yes, if yes, please provide name: _____

Have you previously been diagnosed with a mental health condition? No Yes

If so, what condition(s)?

Have you been in therapy before? No Yes

If yes, when, where, and with whom?

Have you ever been hospitalized for a psychiatric reason? No Yes

When and for what reason?

Have you ever attempted suicide? No Yes

When / How?

Are you currently involved with any community resources? (support groups, social services, school based services, other social supports)

Strengths/Weaknesses:

Please list 3 personal strengths:

1. _____
2. _____
3. _____

Please list 3 personal weaknesses:

1. _____
2. _____
3. _____

Is there any additional you would like to provide about yourself?
