


**C**enter for  
**A**cademic and  
**P**sychological  
**S**ervices 

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ADULT

PSYCHOSOCIAL HISTORY

QUESTIONNAIRE

I. BACKGROUND TO THE EVALUATION

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

Date of Birth: \_\_\_\_\_

Why are you seeking evaluation now and what are your greatest concerns?

At what age would you say these problems began? (Circle any one)

- a. 0 - 7 years
- b. 8 - 12 years
- c. 13 - 15 years
- d. 16 - 21 years
- e. 22 to present

Goals for the evaluation:

II. RELEVANT HISTORY

FAMILY HISTORY

Are you currently in an intimate relationship?    Yes    No  
If yes, for how long?

- a. Less than 3 months
- b. 3 - 6 months
- c. 7 months - 1 year
- d. 1 - 5 years
- e. 5 - 10 years
- f. 10+ years

What is your current marital status?

- a. Never married
- b. Married
- c. Separated
- d. Divorced
- e. Widowed

Spouse/Significant Other

NAME                      DOB                      AGE    EDUCATION    QUALITY OF YOUR RELATIONSHIP

Do you have children?                      Yes    No

If yes, details:

NAME                      DOB                      AGE    GRADE                      QUALITY OF YOUR RELATIONSHIP

**EXTENDED FAMILY RELATIONSHIPS**

**PARENTS      AGE      ALIVE/DECEASED      REASON FOR DEATH      QUALITY OF YOUR RELATIONSHIP**

**SIBLINGS**

**FAMILY MEDICAL HISTORY**

Are there any medical illnesses that run in your family? Yes      No  
If yes, details:

Is there anyone in your family who has:

**LIST FAMILY MEMBER**

- \_\_\_\_\_ had problems with anxiety or depression
- \_\_\_\_\_ abused alcohol or other drugs
- \_\_\_\_\_ had any psychiatric illness
- \_\_\_\_\_ been in trouble with the law
- \_\_\_\_\_ had seizures or other neurological problems
- \_\_\_\_\_ had Tourette's Syndrome or vocal tics
- \_\_\_\_\_ a movement disorder or any unusual movements
- \_\_\_\_\_ had heart problems
- \_\_\_\_\_ had thyroid problems
- \_\_\_\_\_ had high blood pressure
- \_\_\_\_\_ had attentional problems
- \_\_\_\_\_ had learning disabilities

**DEVELOPMENTAL HISTORY**

As far as you know, were there any problems with your mother's pregnancy or delivery of you? Yes      No  
If yes, details:

As far as you know, did you have any difficulty learning to walk, talk, or sit-up on time? Yes      No  
If yes, details:

Did you have any childhood illnesses? Yes      No  
If yes, details:

Did your parents complain you were difficult to control as child? Yes      No      Not Sure  
If yes, during what ages did they have this complaint? (Circle all that apply)  
a. 0 - 7 years                              d. 16 - 21 years  
b. 8 - 12 years                             e. 22+ years  
c. 13-15 years

Did you have normal relationships with your peers when you were a child? Yes      No  
If no, details:

**SCHOOL HISTORY**

Did you have any trouble starting school in kindergarten or first grade? Yes No

Did you ever repeat a grade? Yes No  
If yes, indicate which grade and briefly describe the reasons:

Were you ever in any special classes? Yes No  
If yes, what kind(s) of special classes were you in?

How would you describe your grades in school?  
a. Worse than average  
b. Average  
c. Better than average

What was your best subject in school?

What was your worst subject in school?

Did your parents and teachers think you did as well as you could? Yes No Not Sure  
If not, what were their complaints?

What is the highest level of school that you have completed?  
a. 8th grade or less d. 3-4 years of college  
b. High school or less e. Postgraduate  
c. 1-2 years of college

Were you ever truant from school? Yes No  
If yes, how often and during what grades?

Were you ever expelled or suspended from school? Yes No

Did you ever get in any physical fights at school? Yes No  
If yes:

During which grades did you get into fights?  
a. K - 6th grade  
b. 7th - 8th grade  
c. High School  
d. Other

How many times did you get into fights?  
a. 1 time  
b. 2 - 5 times  
c. 6 - 10 times  
d. 10+ times

Did you sometimes start the fight? Yes No Not Sure  
Did you ever use a weapon in a fight? Yes No Not Sure

**MEDICAL HISTORY**

How long since your last physical exam?  
a. Never had one d. 1 -2 years  
b. Less than 6 months e. 2+ years (when? \_\_\_\_\_)  
c. 6 months to 1 year

What were the results?

**INIT. QSTNNR - 5**

Name of Physician:

Address:

Phone #:

Do you exercise regularly?    Yes    No

If yes, details:

Do you have any medical problems currently?    Yes    No

If yes, details:

Indicate and explain below if any of the following have ever been part of your medical history:

- hospitalized medically
- loss of appetite, diarrhea, constipation, nausea, vomiting
- ulcers
- heart problems
- liver disease
- vision problems, glaucoma
- seizures
- high blood pressure
- troubled by chest pain or shortness of breath
- injury to your head
- ever lost consciousness

If yes, what was your first memory afterwards?

- encephalitis or brain infection
- unusual body movements, tics,  
unusual vocal noises
- thyroid problems
- sleep problems
- recent weight changes,  
weight problems
- decreased interest in sex
- decreased sexual functioning
- unusual or excessive bleeding
- allergies

Explain the past medical problems you indicated above:

Do you take any medications?    Yes    No

If yes, details:

Do you take any over-the-counter medications?    Yes    No

If yes, details:

Do you have any allergies to medications?    Yes    No

If yes, details:

**(FOR FEMALES ONLY)**

Do you use birth control pills?    Yes    No

Are you trying to get pregnant?    Yes    No

Do you intend to get pregnant within the next 5 years?    Yes    No

Are you using any birth control?    Yes    No

Are you currently nursing?    Yes    No

PSYCHIATRIC HISTORY

Have you ever:

- seen a counselor or psychiatrist before
- been hospitalized for a psychological or psychiatric problem
- had problems with depression
- had problems with anxiety

If yes, details (when, where, treatment, and outcome; what was helpful?):

DRUG/ALCOHOL USAGE

How much do you smoke?

- a. Never smoked
- b. Have quit for 1 year+
- c. Have quit for less than 1 year
- d. Less than half a pack per day (ppd)
- e. Half to 1 ppd
- f. 1 - 2 ppd
- g. 2+ ppd

How much caffeine do you drink, including caffeinated tea and soda?

- a. None
- b. 1 - 2 cups per day
- c. 3 - 4 cups per day
- d. 5 - 6 cups per day
- e. 7 - 10 cups per day
- f. 10+ cups per day

Do you ever use diet preparations?      Yes      No  
If yes, which ones?

How much alcohol do you drink in a week?

- a. I never drink
- b. 0 - 1 drinks
- c. 2 - 4 drinks
- d. 5 - 10 drinks
- e. 10+ drinks

Did you ever drink more heavily?      Yes      No  
If yes, details:

Have you ever used any drugs recreationally?      Yes      No

Have you ever experienced blackouts?      Yes      No

<u>Drug</u>	<u>Used (Y or N)</u>	<u>Frequency</u>
Pot, marijuana, hashish, grass	_____	_____
Amphetamines, stimulants, uppers, speed	_____	_____
Cocaine, coke, crack	_____	_____
Barbiturates, sedatives, downers, sleeping pills, Seconal, Quaaludes	_____	_____
Tranquilizers, Valium, Librium	_____	_____
Heroin	_____	_____
Other opiates (Iodine, Demerol, morphine, methadone, Darvon, opium	_____	_____
Psychedelics (LSD, mescaline, peyote, mushrooms, DMT, PCP)	_____	_____
"Designer" Drugs (Ecstasy, X)	_____	_____
Inhalants (Paint, thinner, gasoline, lacquer)	_____	_____

Do you use drugs recreationally now?      Yes      No  
If yes, what and how often?

**INIT. QSTNNR - 7**

Have you ever misused prescription or over-the-counter drugs? Yes No  
If yes, details:

**EMOTIONAL HISTORY**

How would you describe your mood most of the time?

- a. Normal and fairly stable
- b. Anxious or nervous
- c. Depressed, sad, or blue
- d. Labile; mood changes alot
- e. Other \_\_\_\_\_

Describe any mood problems you have:

Do you have problems with your temper? Yes No  
If yes, details:

Did you ever have any problems with your temper? Yes No  
If yes, details:

Have you ever lost your temper enough to hurt anyone or damage any property? Yes No  
If yes, details:

Do other people complain about your temper? Yes No Not Sure

Do you have trouble in your relationships with others? Yes No  
If yes, details:

**OCCUPATIONAL HISTORY**

How many jobs have you had since high school?

- a. 1 - 2
- b. 3 - 5
- c. 6 - 10
- d. 10+

Your current job aside, briefly describe any past job duties that have been difficult:

What is your current occupation?

How long have you been at your current job?

Briefly describe your current job duties:

**INIT. QSTNNR - 8**

Are there particular parts of your current job that present special difficulties for you? Yes No  
If yes, details:

**LEGAL HISTORY**

Did you ever get into trouble for stealing or damaging property as a child or teenager? Yes No  
If yes, details:

Have you ever been arrested or in trouble with the law? Yes No  
If yes, details:

Do you have a driver's license? Yes No  
If yes:

How many traffic tickets (not parking tickets) have you ever gotten?

- |          |          |
|----------|----------|
| a. None  | d. 4 - 5 |
| b. 1     | e. 5+    |
| c. 2 - 3 |          |

How many car accidents have you ever been in?

- |         |       |
|---------|-------|
| a. None | d. 3  |
| b. 1    | e. 4+ |
| c. 2    |       |

If no, why don't you have a driver's license?

**MILITARY HISTORY**

Have you served in the military? Yes No  
If yes, details (highest rank, special honors, duties, discharge status):

**PLEASE NOTE ANY OTHER BACKGROUND INFORMATION THAT IS IMPORTANT FOR THE EVALUATOR TO KNOW ABOUT YOU:**