Joseph Edwards, Psy.D. PLLC
Child, Adolescent & Family Psychology

Adult History Questionnaire

I am asking you to complete this questionnaire to assist me in focusing on the concerns you have, and to better understand you. Some of the information requested may not seem related to you and your problems, but often such seemingly unrelated information becomes very important in my understanding of your situation. You may not immediately remember the answers to all of the questions. However, I would appreciate your trying to complete the questionnaire as accurately and completely as possible. Family members, baby books, and close friends etc., can be good resources in completing this questionnaire. If you run out of space in answering a question, feel free to attach a sheet of paper. Your completion of this questionnaire **will help reduce the time needed to make an accurate evaluation of your difficulties** as well as help to focus my attention to your most relevant concerns. If you do not understand any of the questions please feel free to call me.

Please describe below the reason you are seeking treatment: _____

When did this problem begin? _____

What have you tried to do about it, and what do you think will help? _____

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Today's date: _____

Your Name:_____ Birthdate:_____Age:_____

Your Social Security Number: _____

Gender: Male Female Non-binary (Please circle) Preferred pronoun: _____

Home address:_____

_____

City State Zip Code

Home Phone: _____ Cell Phone: _____ Email:_____

Emergency Contact Person: _____ Phone number: _____

Please list all members living in your home.:

Name	Age	Relationship to You

BRIEF FAMILY HISTORY

Mother's Name: _____ [Please circle (Biological, Adoptive or Stepmother)]
Mother is: Living Deceased* (Please circle) *Cause and year of death: _____
Ethnic Background: _____ Religious Affiliation: _____
Marital Status: Single Married Divorced Remarried Widowed (Please circle)

Father's Name: _____ [Please circle (Biological, Adoptive or Stepmother)]
Father is: Living Deceased* (Please circle) *Cause and year of death: _____
Ethnic Background: _____ Religious Affiliation: _____
Marital Status: Single Married Divorced Remarried Widowed (Please circle)

Other Primary Caretaker's Name: _____
What is/was his/her relationship to you? _____

Sibling Information

Sibling Name(s)	Sibling Relationship (Biological/Adoptive/Step/Half)	Age of Sibling

Marital History

Name of Spouse(s)	Date of Marriage(s)	Status of the Marriage(s) (Married/Remarried/Separated*/Divorced*)	*Date
_____	_____	_____	_____
_____	_____	_____	_____

PRENATAL/BIRTH HISTORY

Are you aware of any problems/complications with your mother's pregnancy with you? If yes, please describe:
_____
_____

Did your mother take any medications during pregnancy (includes all medications, vitamins, birth control pills,etc...)
_____
_____

Did she smoke, consume alcohol, or use any drugs during her pregnancy? If yes, please describe:
_____

Were you born: on time early* late* (circle one) *By how many weeks? _____

Your condition at birth: Breathed immediately _____ Cried immediately ____ Required oxygen _____
Had Seizures _____ Required Intensive Care _____
Problems during your first week of life: Incubator ____ Yellow skin ____
Bleeding _____ Infection _____ Special concerns: _____

DEVELOPMENTAL HISTORY

Are you aware of any eating or sleeping problems you had as a child? If yes, please describe:
_____
_____
_____

Please list any significant illnesses you had as a child and at what age you had them?
_____
_____
_____

Below, please indicate if there were any delays or advances in performing the following tasks. If you were delayed, please write "D"; if you were advanced, please write "A"; if you do not know or recall, please write "DK". Leaving an item blank implies you completed the developmental task at an age appropriate time.

Held head erect _____
Sat alone _____
Crawled _____
Stood alone _____
Walked _____
Ran with good control _____
Are you left or right handed? _____

Fed self _____
Drank from a cup _____
Talking _____
Started toilet training _____
Ended toilet training _____
Dressed Self _____

Please mark if you experienced any of the following events during your childhood.

Multiple moves _____
Separation from family (i.e. foster care) _____
Physical Abuse _____
Sexual Abuse _____
Verbal/Emotional Abuse _____
Other Trauma _____(please explain below)
Parental Separation _____
Parental Divorce _____
Parental Remarriage _____
Death of a Parent _____
Death of a Sibling _____
Other _____ (please explain below)

HEALTH/MEDICAL HISTORY

Please list the name & address of your primary physician: _____
_____
_____

Do you know your physician well? _____ yes _____ no
Do you take any medication? _____ yes _____ no If yes, please list current medications state for what condition:_____
_____
_____
_____

When was your last physical exam? _____
_
Please list any other physicians that you see regularly and why: _____
_____

Please **mark if** you have had any of the following:

Accidents: _____
Anemia: _____
Acid Reflux: _____
Hepatitis: A _____ B _____ C _____
Vision problems: _____
Speech/Language problems: _____
Foot problems: _____
Skin abnormalities: _____
Seizures or convulsions: _____
Allergies: _____
High fever, unknown cause: _____
Pneumonia: _____
Cancer: _____
Problem in bladder or bowel: _____
Hearing problems: _____
Difficulties eating or feeding self: _____
Motor problems: _____
Unusual fears: _____
Sleep difficulties: _____
Unusual behaviors: _____
Other illnesses/problems: _____
_____

Have you ever been hospitalized? (Name of hospital, date & reason for hospitalization):
_____
_____

Have you ever received any previous psychotherapy or counseling? _____
If yes, describe: _____
With whom & for how long? _____
What was the outcome of that treatment experience? _____
_____

SCHOOL/WORK HISTORY

What is your highest grade level completed? _____
Were you ever held back a year in school? _____ yes _____ no Grade held: _____
Were you ever involved in special education? _____ If so, when and what kind? _____
_____
Have you ever been diagnosed with a learning disability? _____yes _____ no
If yes, describe: _____
What was your attitude toward school? _____
Other comments about school: _____
_____
Are you currently working? ____yes ____no
If yes, where are you employed? _____
What is your typical work schedule (list days and times)? _____
_____
_____
Have you ever had difficulty keeping steady employment? ____yes ____no
If yes, please explain: _____
_____
_____
Have you ever been fired or asked to resign from a job? ____yes ____no ____
If yes, please describe:
_____
_____

Other comments about work:
_____
_____
_____

SOCIAL BEHAVIOR & ACTIVITIES

Below, **please mark** anyone with whom you have a difficult relationship:

Spouse _____ Parent _____
Employer _____ Sibling _____
Child _____ Friend _____
Neighbor _____ Other: _____

Are you currently experiencing any physical, emotional/verbal, or sexual abuse within a relationship?
If yes, please describe: _____
_____
_____
—

Have you experienced any physical, emotional/verbal, or sexual abuse within previous relationships?
If yes, please describe: _____

_____

_____

Are there any particular family stresses of which you are aware that may have a bearing on your problem?
If yes, please describe: _____

_____

Are you currently experiencing any legal problems? _____ yes _____ no
If yes, please explain: _____

_____

What do you consider to be some of your strengths? _____

_____

_____

_____

What activities do you enjoy doing? _____

_____

_____

_____

What things/activities present the greatest difficulty for you? _____

_____

_____

_____

Family Medical/Family Psychiatric History

Please indicate whether there are any relatives (including parents, grandparents, aunts, uncles and cousins), who have (or have had in the past) the same or a similar problem for which you are seeking evaluation. Also indicate for these persons whether there are serious, chronic or recurrent illnesses or abnormalities such as birth defects, miscarriages, diabetes, convulsions or epilepsy (fits), mental or emotional disorders, substance abuse problems, slow development, mental retardation, school problems, cerebral palsy, muscular disorders, cancers, leukemia, thyroid disease, deafness or blindness, speech or language problems, reading or learning disabilities. (Please be as specific as possible).

Mother_____
Mother's mother_____
Mother's father_____
Mother's brothers & sisters_____
Mother's maternal grandmother_____
Mother's maternal grandfather_____
Mother's paternal grandmother_____
Mother's paternal grandfather_____
Mother's aunts & uncles_____
Mother's cousins_____

Father_____
Father's mother_____
Father's father_____
Father's brothers & sisters_____
Father's maternal grandmother_____
Father's maternal grandfather_____
Father's paternal grandmother_____
Father's paternal grandfather_____
Father's aunts & uncles_____
Father's cousins_____

SUBSTANCE ABUSE HISTORY

NOTE: The law does not require me to report substance use information. Please answer the following items as honest as possible.

Do you currently smoke? ____yes ____no
If yes, how often do you smoke (i.e. daily, days per week, month, etc.) _____
Approximately how many packs do you smoke per day? _____
Have you ever tried to quit smoking? ____yes ____no
If yes, please explain? _____
How often do you consume alcohol (i.e. daily, days per week/month, etc.) _____
Approximately how much alcohol do you consume per use? _____
Do you use illegal drugs/substances? ____yes ____no
If yes, what substance(s) do you typically use? _____
_____
How often do you use illegal drugs (i.e. daily, days per week/month, etc.)?_____
Approximately how much of the drug(s) do you consume per use? _____
Have you ever been involved in substance abuse treatment? _____
Have you ever had problems with the law, family, school, or work because of drug use? ____yes ____no
If yes, please explain: _____
_____
_____
_____

If you would like to provide any additional information, which you feel would be important for understanding you and your particular concerns, please use the space below.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Thank you for completing this form.