Stepping Stones Counseling Services

Adult Form

Thank you for completing this form. The information you provide will help create a treatment plan tailored to meet your needs. The purpose of this questionnaire is to get a complete picture of your marital and/or family background. By obtaining this information we can save valuable interview time. Therefore, answering these routine questions as fully and as accurately as you can in appreciated. All case records are strictly confidential. NO ONE is permitted to see your case record without your permission in writing (except in situations deemed potentially life-threatening or if court ordered). If you have questions about the questionnaire, please feel free to ask at any time. If you do not wish to answer a question, you may write, "I do not wish to answer."

Patient Name_____Date:_____

Address_____ Home #_____

City _____ State _____ Zip Code_____

Gender:__ male __female Age:_____ Date of Birth _____

Employer: _____ Occupation: _____ Work# _____

Marital Status: __Single __Married __Widowed __ Divorced __ Separated

__ Engaged __ Living Together

Spouse's Name: _____ Date of Birth_____ Age _____

Employer: _____ Occupation: _____ Work# _____

Emergency Contact: _____Telephone # _____

Name of Children:	Date of Birth:	Grade:	Lives with you
_____	_____	_____	__ yes __no
_____	_____	_____	__yes __no
_____	_____	_____	__yes __no
_____	_____	_____	__yes __ no

Current Medications and Medication Prescriber:

_____

_____

_____

Name and telephone numbers of all physicians currently providing care:

Physician: Telephone Number:

_____ _____

_____ _____

_____ _____

Have you, or anyone in your family ever attempted or committed suicide? ___ yes ___ no

If yes, please indicate whom and when:

_____

_____

What type of counseling or treatment have you had before? _____

_____

Family History:

<u>Father:</u>

Living? __yes __no Father's age _____ If deceased, his age when he died? _____

Cause of death: _____ Your age at time of his death_____

Father's occupation: _____

<u>Mother:</u>

Living? __ yes __ no Mother's age_____ If deceased, her age when she died? _____

Cause of death: _____ Your age at the time of her death _____

Mother's occupation: _____

Please check any of the following which apply and indicate the family member involved such as spouse, child, father, mother, brother, sister, yourself and so on.

Event: Family member involved

__ death in family _____

__ divorce _____

__ trouble with the law _____

__ financial trouble _____

__ serious illness _____

__ mental illness _____

__ job or school difficulty _____

__ drugs _____

__ alcohol _____

__ Interpersonal problems _____

__ sexual abuse/assault _____

__ physical abuse/assault _____

__ depression _____

__ suicide/homicide _____

__ serious accident _____

__traumatic event _____

__ other _____

Have you ever used: (check all that apply) What age?

__ alcohol __sedatives __barbiturates __tobacco __heroin __LSD
__caffeine __methadone __ cocaine/crack __stimulants __tranquilizers
__pain medication __PCP __marijuana __inhalants, glue, Freon , butane, gasoline

Has anyone in your family ever been concerned about your abuse of drugs and alcohol __yes __no

Current signs/ symptoms

0= None

1= Mild (Impacts quality of life but no significant impairment of the day-to-day functioning)

2=Moderate (significant impact on quality of life and/or day-to-day functioning)

3=Severe (profound impact on quality of life and day-to-day functioning)

Depressed mood (sadness) 0 1 2 3

Eating patterns (increase/decrease) 0 1 2 3

Sleep patterns (increase/decrease) 0 1 2 3

Elimination disturbance 0 1 2 3

Low energy 0 1 2 3

Problems with coordination 0 1 2 3

Poor concentration 0 1 2 3

Agitation (can't be still) 0 1 2 3

Mood swings 0 1 2 3

Irritability (anger) 0 1 2 3

General anxiety (nervousness) 0 1 2 3

Panic attacks 0 1 2 3

Phobias (excessive fears of certain things) 0 1 2 3

Repeating unwanted thoughts or behaviors 0 1 2 3

Binging 0 1 2 3

Purging 0 1 2 3

Anorexia 0 1 2 3

Suspicious of others 0 1 2 3

Hearing things without apparent cause 0 1 2 3

Seeing things without apparent cause 0 1 2 3

Aggressive behaviors 0 1 2 3

Not complying with rules or laws 0 1 2 3

Sexual problems 0 1 2 3

Any other physical/mental problems- please specify

_____ 0 1 2 3

_____ 0 1 2 3