ADULT QUESTIONNAIRE

This questionnaire asks you to respond to a series of questions. This type of background information helps us understand your history and ways we can help you. Please complete as best you can, providing that information which you are comfortable putting into writing. When appropriate, it is also helpful for you to bring copies of any previous educational, medical, or psychological reports.

IDENTIFYING INFORMATION

Your Name: _____ Date of Birth:_____ Gender (circle): Male Female Age _____

Marital Status (circle):

Never Married Partnered Married Separated Divorced Widowed

If married, Spouse's Name: _____ Phone Numbers:

Home:_____

Cell:_____

Office: _____

If we need to contact you, which number(s) would you prefer that we use? : _____

Is it okay to leave a message at that number(s)? Yes No

Primary Care Physician:_____ Phone:_____

Referral Source:_____

REASON FOR REFERRAL

Describe the reason(s) for seeking services:

_____

_____

_____

_____

_____

Have you received a previous evaluation or intervention for similar reasons (circle)? Yes No

If Yes, when and with whom? _____

Amie Allain, Ph.D.
2316 Timber Shadows, Suite 200 * Kingwood, Texas 77339
P: (281) 217-2505*E: dr.amie.allain@gmail.com*W: www.thewillowpartnership.com

MEDICAL INFORMATION/HISTORY

Have you ever been diagnosed with any behavioral, educational, medical, neurological, or psychiatric disorder, such as Attention Deficit/Hyperactivity Disorder (ADHD), Learning Disorder (LD), Anxiety or Depression? Yes No

If *Yes*, please specify:_____
_____
_____

Are you on any medication at this time? Yes No

If *Yes*, please provide the following:

Medication	Dosage/Times per day	Purpose	How long on this medication?	Who prescribed?

Medical Treatment (Date of most recent medical exam): _____

Primary Care Physician: _____Phone:_____

Do you have any sleeping difficulties (trouble falling asleep, staying asleep, waking)? Yes No
If *Yes*, please describe:_____

Do you have any unusual eating patterns or habits? Yes No
If Yes, please describe: _____
_____
_____
_____
_____

Do you have any health-related concerns that might be affecting your emotional health at the current time (e.g., preoccupation with health, current health condition and associated stressors)?

Yes No

If yes, please explain: _____
_____
_____

Allergies (e.g., Food or other):_____

Vision: Date of most recent vision exam:_____

Do you have any vision problems: Yes No
If *Yes*, corrected with: Glasses or Contact lenses

Hearing Date of most recent hearing exam:_____
Do you have any hearing problems: Yes No
If *Yes*, have they been treated?_____

Illness: Place a check next to any illness/condition you have had.

Illness or Condition	**Illness or Condition**	**Illness or Condition**
___ Anemia	___ Epilepsy or seizures	___ Loss of consciousness
___ Arthritis (juvenile)	___ Fainting	___ Malnutrition
___ Bleeding problems	___ Fatigue (if chronic and severe)	___ Measles
___ Bone or joint disease	___ Hay fever	___ German measles
___ Broken bones	___ Head injury	___ Meningitis
___ Cancer	___ Headaches (frequent or severe)	___ Mumps
___ Chicken pox	___ Heart disease	___ Paralysis
___ Diabetes	___ Hepatitis	___ Rheumatic fever
___ Diphtheria	___ High blood pressure (hypertension)	___ Scarlet fever
___ Eczema or hives	___ High fever (greater than 104 degrees)	___ Tuberculosis
___ Encephalitis	___ Jaundice	___ Whooping cough

Explain any of the above checked items and/or any other medical illnesses (please include age at the time of illness): _____
_____
_____
_____
_____

Have you ever been taken to the Emergency Room? Yes No

If *Yes*, please list why and how old you were at the time of the visit: _____

_____

EMOTIONS/BEHAVIOR

Do you (or others) have any concerns regarding your behavior either at home, in public or at work?

Yes No

If *Yes*, please describe:_____

_____

_____

Do you experience or display more anger and aggression compared to others your age? Yes No

If *Yes*, please describe: _____

_____

Do you experience or display more sadness or irritability compared to others your age? Yes No

If *Yes*, please describe:_____

_____ Do you experience or display more fears or worries compared to others your age? Yes No

If *Yes*, please describe:_____

_____

Do you experience physical symptoms of anxiety (e.g., racing heart, sweaty palms)? Yes No

If *Yes*, please describe:_____

_____

Do you experience intrusive thoughts that are difficult to control or "shake off?" Yes No

If *Yes*, please describe:_____

_____

What are your strengths or best qualities?: _____

_____

_____

What about yourself would you like to change or improve?: _____

_____

_____

_____

_____

FAMILY/RELATIONSHIP HISTORY

Current Living Situation: Who lives at home with you?_____

_____

Describe any current or previous family stressors that might be affecting you at the current time (e.g., death, divorce, trauma):

_____

_____

_____

_____

_____

Describe the relationship and/or levels of support you have experienced from key family members, currently and in the past: _____

_____

_____

_____

_____

Has this level of support been consistent with your needs and/or expectations? Yes No Not Sure

If no or unsure, please explain: _____

_____

Are you in a committed relationship? Yes No It's Complicated

Please explain: _____

_____

_____

_____

Please list and/or describe past key relationships that may be important in understanding your relational history: _____

_____

_____

_____

Maternal Family History: Is your mother still living? Yes No

As far as you know, does/did your mother ever experience any of the following:

Medical Problems	YES	NO	Not Sure
Learning Problems	YES	NO	Not Sure

Drug/Alcohol Abuse	YES	NO	Not Sure
Depression	YES	NO	Not Sure
Anxiety	YES	NO	Not Sure
Bipolar Disorder	YES	NO	Not Sure
ADHD or ADD	YES	NO	Not Sure
Personality Disorder	YES	NO	Not Sure

Other emotional/behavioral/psychological difficulties: YES NO Not Sure

Please provide additional information for any of the items marked "YES" above:

_____

_____

_____

Paternal Family History: Is your father still living? Yes No

As far as you know, does/did your father ever experience any of the following:

Medical Problems	YES	NO	Not Sure
Learning Problems	YES	NO	Not Sure
Drug/Alcohol Abuse	YES	NO	Not Sure
Depression	YES	NO	Not Sure
Anxiety	YES	NO	Not Sure
Bipolar Disorder	YES	NO	Not Sure
ADHD or ADD	YES	NO	Not Sure
Personality Disorder	YES	NO	Not Sure

Other emotional/behavioral/psychological difficulties: YES NO Not Sure

Please provide additional information for any of the items marked "YES" above:

_____

_____

_____

EDUCATIONAL/OCCUPATIONAL HISTORY

Current Occupation: _____

How satisfied are you with your current occupation? _____

_____

_____

If different from your current occupation, what would your "ideal" or "dream" job be? _____

_____

_____

Highest Level of Education:_____

If currently a student, name of College/University: _____

Did your teachers (or parents/caregivers) report anything unusual about your early school performance? Yes No

IF *Yes*, explain: _____

_____

_____

Did you show significant strengths or weaknesses in any academic area at an early age? Yes No

If *Yes*, explain:_____

_____

_____

Did you skip or repeat any grades in school? Yes No

If *Yes*, explain:_____

_____

_____

Other relevant information related to previous school performance: _____

_____

_____

_____

_____

SOCIAL SKILLS/ACTIVITIES

About how many close friends do you have? (circle) None One Two or three Four or more

Is this a comfortable number of close friends; would you wish for more or less? _____

_____

Would you describe yourself as introverted, extroverted, or somewhere in between? _____

_____

About how many times a week do you do things with friends?_____

Are you satisfied with this frequency of weekly socialization? Yes No
Please explain: _____

_____

Compared to others, how do you get along with other people? (circle)

Below Avg Average Above Avg

Do you participate in any regular social activities or social organizations? Yes No

If *Yes,* list:_____

What do you enjoy doing?_____

_____

Is there any other information that you think may help us in understanding and working with you?_____

_____

_____

_____

_____

_____

_____