Triangle Center for Behavioral Health
Lisa Senatore, Ph.D., PLLC
Adult History Questionnaire

Patient Name:_____ Age:_____ Today's Date:___/___/___

Biological Sex:_____ Identified Gender/Pronouns:_____

Birthdate:_____ Race:_____

Address:_____

City:_____ State/Province:_____ Zip/Postal Code:_____

Work/Mobile Phone:_____ Home Phone:_____

Ok to leave a message? ☐ Yes ☐ No Ok to leave a message? ☐ Yes ☐ No

Ok to send text messages? ☐ Yes ☐ No

Email Address: _____

Please briefly state your concerns that led to you to arrange an evaluation:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Who referred you here?

Name:_____ Address:_____

Phone number:_____

Family Information:

Relationship Status (circle): single married long-term relationship divorced widowed
other (explain): _____

Who lives in the home with you?:

Name/Age/Relation:_____ Name/Age/Relation:_____

Name/Age/Relation:_____ Name/Age/Relation:_____

Name/Age/Relation:_____ Name/Age/Relation:_____

Immediate family outside of the home?:

Name/Age/Relation:_____ Name/Age/Relation:_____

Name/Age/Relation:_____ Name/Age/Relation:_____

Developmental History: Please answer the following questions about yourself.

Were there any problems with your mother's pregnancy with you or with your birth that you know of? Explain:

_____

_____

What were you like as an infant/toddler (if you know)?:

Motor Development (Sitting, Walking)	☐ Normal	☐ Fast	☐ Slow
Speech and Language	☐ Normal	☐ Fast	☐ Slow
Self-help Skills (dressing, toileting, hygiene)	☐ Normal	☐ Fast	☐ Slow
Handedness	☐ Right	☐ Left	☐ Both
Toilet Trained:	☐ Normal	☐ Fast	☐ Slow

Comments: _____

Check all that apply to you as an infant/toddler/preschooler (if you know):

Activity:	Emotional:	Interpersonal:
☐ Rocking/Head banging	☐ Shy or timid	☐ Affectionate
☐ Impulsive	☐ Fearful	☐ Distant/Hard to engage
☐ Daredevil	☐ Cautious	☐ More interested in things than in people
☐ Temper outbursts	☐ Happy	☐ Slow to warm up
☐ Overactive	☐ Curious	☐ Aggressive
☐ Into everything	☐ Irritable	☐ Clingy
☐ Easy to manage	☐ Sad	☐ Stubborn
☐ Hard on belongings		☐ Independent

Medical History

Have you had any of the following?

	No	Yes	Date/Age/Description
Measles, Mumps, Rubella	☐	☐	_____
Migraine	☐	☐	_____
Severe Abdominal Pain	☐	☐	_____
Cancer	☐	☐	_____
Chicken Pox	☐	☐	_____
Whooping Cough	☐	☐	_____
RSV	☐	☐	_____
Severe Flu	☐	☐	_____
Strep Throat	☐	☐	_____
Meningitis/ Encephalitis	☐	☐	_____
Abscessed Ears	☐	☐	_____
Tubes in Ears	☐	☐	_____
Allergies	☐	☐	_____
Asthma	☐	☐	_____
Seizures	☐	☐	_____
Heart/Blood Pressure Problems	☐	☐	_____
Thyroid/Endocrine Problems	☐	☐	_____
Diabetes	☐	☐	_____
Gastrointestinal Problems	☐	☐	_____
Nervous System Problems	☐	☐	_____

Gynecological Problems	☐	☐	_____
Sexual Problems	☐	☐	_____
Head Injuries	☐	☐	_____
Other Injuries	☐	☐	_____
Hospitalizations	☐	☐	_____
Hearing Problems	☐	☐	_____
Vision Problems	☐	☐	_____
Other	☐	☐	_____

Do you currently take medication for a medical illness? ☐ No ☐ Yes
If yes, please describe: _____

_____

Do you have known allergies to any medications? _____

_____

Do you wear glasses or contact lenses? If so, to see close up or far away?_____

_____

Self Care:

Do you currently exercise? ☐ No ☐ Yes (describe routine): _____

_____

Describe your diet: ☐ Eat too much ☐ Eat too little ☐ Just right ☐ Picky ☐ Rituals surrounding food ☐ Generally Healthy ☐ Too much sugar/processed food ☐ Eat out frequently
Comments about diet:_____

Describe your sleep hygiene: ☐ Sleep too much ☐ Sleep too little ☐ Just right ☐ Trouble falling asleep ☐ Go to bed too late ☐ Night waking ☐ Can't get back to sleep ☐ Wake too early ☐ Trouble waking up/getting out of bed ☐ Loud snoring ☐ Sleep apnea ☐ Teeth grinding

Time you usually fall asleep during the week: _____ Time you wake up: _____

Do you meditate or engage in mindfulness practice? ☐ No ☐ Yes (describe routine):

_____

Family Medical/Psychiatric History:

Have any of your **biological relatives** had physical health problems?

☐ No ☐ Yes ☐ Don't know

If yes, please describe whom/illness/treatment: _____

_____

_____

_____

_____

Have any of your **biological relatives** had mental health problems?

☐ No ☐ Yes ☐ Don't know

If yes, please describe whom/illness/treatment: _____

_____

_____

_____

_____

Outside of biological relatives, are there **any other people with whom you have significant contact** who have medical or psychiatric problems that affect you?

☐ No ☐ Yes ☐ Don't know

If yes, please describe whom/illness/treatment: _____

_____

_____

_____

_____

Academic Information:

Highest Level of Education (circle): GED high school some college trade school college degree

(indicate in what area/major) - associates:_____ bachelors: _____ masters: _____

Advanced masters/graduate degree: _____ doctorate: _____

List colleges and universities attended and years:	Degree obtained?	GPA (approx.)?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous schools (preschool, elementary, middle, high school) attended and grade levels:	Academic Struggles?		Behavioral Struggles?	
_____	☐ Yes	☐ No	☐ Yes	☐ No
_____	☐ Yes	☐ No	☐ Yes	☐ No
_____	☐ Yes	☐ No	☐ Yes	☐ No
_____	☐ Yes	☐ No	☐ Yes	☐ No
_____	☐ Yes	☐ No	☐ Yes	☐ No

Repeated Grade?: ☐ No ☐ Yes: reasons: _____

_____

_____

Skipped Grade?: ☐ No ☐ Yes: reasons: _____

_____

_____

Behavior Consequences?

In-school Suspensions: ☐ No ☐ Yes: grade level and reasons: _____

Out-school Suspensions: ☐ No ☐ Yes: grade level and reasons: _____

Expulsions? ☐ No ☐ Yes: grade level and reasons: _____

How did /would your teachers generally describe your behavior at school? _____

_____

_____

_____

Learning Difficulties/Strengths? ☐ No ☐ Yes (describe):

Has testing ever been completed? ☐ No ☐ Yes: results? (Please provide copies if possible):

Did you have an IEP/504 Plan/accommodations: ☐ No ☐ Yes: details:

Did you have a DEP/gifted services: ☐ No ☐ Yes: details:

What did you like most/dislike most at school?

Which of the following problems, if any, did you have in school?

☐ Did not do homework	☐ Forgot assignments	☐ Below Average reading skills
☐ Failed to check work	☐ Many careless errors	☐ Below Average spelling
☐ Incomplete homework	☐ Incomplete classroom work	☐ Below Average math
☐ Not remaining seated	☐ Disorganization	☐ Below Average written language
☐ Inattention in class	☐ Talked excessively	☐ Below Average handwriting
☐ Distraction	☐ Anxiety	☐ Excessive time to complete work

Further comments on homework, academic functions:

Employment History:

List jobs and years worked at that job:	Full or Part Time?	Reason left?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Further comments on job functioning – how do your difficulties affect your ability to do your job?:_____

_____

_____

_____

_____

Psychosocial Functioning:

Which of the following, if any, describe(s) your interactions with peers as a child?

☐ No friends	☐ Average number of friends	☐ Trouble keeping friends
☐ Few Friends	☐ Socially comfortable	☐ Trouble making new friends
☐ Controlling	☐ Aggressive	☐ Bullying
☐ Excessively shy	☐ Overall social	☐ Socially awkward

Extracurricular/Group Activities as a child/high school/college:_____

_____

_____

_____

_____

Further comments on peer functioning:_____

_____

_____

_____

Current social problems:

☐ No friends ☐ Average number of friends ☐ Trouble keeping friends
☐ Few Friends ☐ Socially comfortable ☐ Trouble making new friends
☐ Talk too loud ☐ Trouble listening in conversations ☐ Talk excessively
☐ Excessively shy ☐ Blurt out things without thinking ☐ Socially awkward
☐ Difficulties with dating ☐ Problems keeping romantic relationships

How would you describe your current social functioning? How do your problems affect your relationships?:_____

_____

_____

_____

Therapy History:

Has you ever received talk therapy? ☐ No ☐ Yes
If no, please go to medication questions.

If yes, please complete the following:
Have you received Cognitive Behavioral Therapy (CBT)? ☐ No ☐ Yes ☐ Don't know

If yes, did it include assigned "homework"? ☐ No ☐ Yes ☐ Don't know

Provider	**Reason for treatment**	**Length of treatment**	**Outcome**

Has your ever taken psychiatric medication? ☐ No ☐ Yes

If yes, please complete the following:

Medication	**Dosage**	**Dates of Use**	**Prescriber**	**Benefits**	**Side Effects**

Have you ever been hospitalized for mental health treatment? Please explain:

_____

_____

_____

Is there anything else you would like us to know about you before we meet?

_____

_____

_____