Kranz Psychological Services, PLLC

ADULT QUESTIONNAIRE

Dear Client: Date:___________________

It is the desire of our staff to have the most complete picture possible of you in order to better understand your difficulties. This questionnaire will help you give us the information we need to help you. Please inform office staff if you are unsure of how to answer a question.

DEMOGRAPHIC INFORMATION

Name:____

DOB: ____________________Sex: __________Age:__________ Race: ___________________

Address:____Phone:________________

Marital Status (circle one): Married Divorced Separated Widowed

With whom do you live? (Check all that apply.)

	YES	NO	
Spouse	____	____	
Other Adults	____	____	How Many? _____
Children	____	____	How Many? _____

FAMILY RELATONSHIPS & HISTORY

How many serious romantic relationships have you had? _____

Have you ever been in an abusive romantic relationship? YES NO

Physical abuse?	YES	NO	If yes, how many? ___
Verbal/Emotional abuse?	YES	NO	If yes, how many? ___
Sexual abuse?	YES	NO	If yes, how many? ___

Did you experience abusive relationships in your childhood? YES NO

Physical abuse?	YES	NO	Perpetrator? _______________
Verbal/Emotional abuse?	YES	NO	Perpetrator? _______________
Sexual abuse?	YES	NO	Perpetrator? _______________

Kranz Psychological Services, PLLC

MEDICAL & DEVELOPMENTAL HISTORY

Did your mother have any complications during pregnancy or at your birth? YES NO UNSURE
If yes, what type of complications?:_______________________________________

Did your mother use tobacco, illicit drugs, or alcohol during her pregnancy? YES NO UNSURE
If so, please describe:_______________________________________

Describe any serious illnesses or accidents requiring a hospital visit/stay (birth complications, sicknesses, falls, burns, cuts, seizures, broken bones, etc.) you have had and your age at the time:
____
____

How often do you see a medical doctor?_______________________________________

Are you currently taking any prescription medications? YES NO
If yes, please list the medication and the reason for taking it:

Medication:	Reason:

Do you see any of the following health care providers regularly?

	YES	NO
General Practitioner	_____	_____
Neurological Examiner	_____	_____
Psychologist/Psychiatrist	_____	_____
Counselor/Therapist	_____	_____

Have you ever been admitted to a psychiatric hospital? YES NO

If yes, please list hospitals and dates: _______________________________________
____

Do you wear glasses? YES NO
If yes, at what age did you begin wearing them?_______________________________________

Describe any other vision problems:_______________________________________

Do you wear hearing aids? YES NO
If yes, at what age did you begin wearing them?_______________________________________

Describe any other hearing problems: _______________________________________

EATING & SLEEPING HABITS

Have you noticed any increase in your appetite lately? YES NO

Have you noticed any decrease in your appetite lately? YES NO

Are you on a special diet? YES NO
If yes, why and what type of diet?____

Do you have complaints about your body weight? YES NO

What time do you wake up in the morning?____

What time do you go to bed?____

Do you have nightmares often? YES NO
If yes, what are the nightmares about?____

Do you have trouble falling asleep? YES NO

Do you have trouble staying alseep? YES
NO

LEISURE ACTIVITIES

What games, recreation, or hobbies do you enjoy? ____
____
____

EDUCATIONAL AND WORK HISTORY

What is the highest grade you completed in school?____

What type of classes did you attend? REGULAR SPECIAL ED. ADVANCED
If you received special education services, in what classes did you receive accommodations? ____

Have you had further education / training? YES NO
If so, what type?____

When was your last date of employment? ____

How many jobs have you had in the last 10 years? ____

What is the longest time you have held one job? ____

Kranz Psychological Services, PLLC

SUBSTANCE USE HISTORY

Do you currently use illicit substances/drugs? YES NO

If yes, please list each substance and frequency of use: ____________________________

____

Have you used drugs in the past, but no longer use? YES NO

If yes, please list each substance and last date of use: ______________________________

____

Do you currently use alcohol? YES NO

If yes, how often?____

How much alcohol do you drink in one sitting?_____________________________________

Have you used alcohol in the past, but no longer use? YES NO

If yes, how often did you drink in the past? _______________________________________

How much alcohol did you drink in one sitting?____________________________________

When was your last drink?____

Have you ever been arrested for DUI or DWI? YES NO

Have you ever attended a substance use treatment program? YES NO

If yes, when? ____

What was the name of the program(s)? ____

LEGAL HISTORY

Have you ever been arrested? YES NO

If yes, how many misdemeanors? _____

What were the charges? ____

If yes, how many felonies? _____

What were the charges? ____

Have you served the following?

Probation	YES	NO
Parole	YES	NO
Jail Time	YES	NO
Prison Time	YES	NO

Kranz Psychological Services, PLLC

OVERALL VIEW OF PROBLEMS / STRENGTHS

Briefly describe what you believe are your 3 main problems:

1.____

2.____

3.____

Briefly describe what you believe are your 3 best strengths:

1.____

2.____

3.____

Briefly describe any additional information about you that would be helpful.

____
____
____
____
____
____
____
____
____