Living Life Counseling Center
Adult Patient Questionnaire

Patient Name: ______________________________ Age: _______ DOB: ___________ Date: ________
Telephone no: (Home) _________________ (Work) ________________ (Cell) ____________________
Emergency Contact Information: Name: _______________________________
Relationship___________________________________
Telephone No: _______________________ Email ____

Please state in your own words why you have come to today:

____
____
____
____
____
____
____

Please check ALL of the following symptoms or thoughts that apply to you **AT THIS TIME or during the past six months:**

Depressed mood
Diminished interests or pleasure
Sleep disturbance
Fatigue
Change in appetite
Hopelessness
Pleasure in few activities
Weight change
Agitation
Excessive worry
I feel like I am losing control.
Irritability
Poor Concentration
Tension
Feelings of panic
Socially withdrawn
Use of alcohol
Use of other drugs
Use of tobacco
Anxiety in social settings
Makes careless mistakes
Does not complete tasks
Difficulty organizing
Forgetful
Confusion
Disorientation

Compulsive checking / counting
Indecisiveness
People talk about me.
Some people want to hurt me.
I feel emotionally distant from others.
I hear voices or sounds others do not hear.
I see things others do not see.
I smell things others do not smell.
Racing thoughts
I do risky or dangerous things.
Little interest in sexual activity
Sexual problems
Gender concerns
I don't like my body.
Binge eating
Self-induced vomiting
Laxative abuse
Excessive fasting
Intense fear of weight gain
Impulsive
I think about hurting myself.
I have tried to hurt myself.
Sometimes I wish I were dead.
I think about hurting someone else.
Exposed to a significant traumatic event
Recurrent distressing dreams

Psychiatric History:

I have received treatment for: Substance abuse □ Mental health issues □ Both □

The treatment occurred at:

□ Other private psychiatrist □ Mental Health Center
□ Hospital □ Other counseling service □ Other facility

If hospitalized, please list dates and where hospitalized________________________________

____

Are you presently being treated? Yes □ No □ If yes, by whom? _______________________

Are you currently being prescribed psychiatric medications? Yes □ No □

If Yes, please list **Current Psychiatric** medications__________________________________

____

Psychological Testing:

Have you ever had psychological testing done in the past? □ Yes □ No

If yes, When______________________and by Whom____________________________

Medical History:

Name of your primary care doctor ____

Phone:_______________________________Date last seen: _________________________

Do you have a history of any medical problem? Yes □ No □ If so, what? __________

____

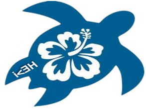
Are you presently being treated for any medical problem? Yes □ No □ If so, what?

____

____

Please list any current **Non-Psychiatric Medications**________________________________

____



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Have you ever been treated for a nutritional problem?	□ Yes	□ No
Do you make yourself sick because you feel uncomfortably full?	□ Yes	□ No
Do you worry you have lost control over how much you eat?	□ Yes	□ No
Have you recently lost more than 14 pounds in a 3 month period?	□ Yes	□ No
Do you believe yourself to be fat when others say you are too thin?	□ Yes	□ No
Would you say that food dominates your life?	□ Yes	□ No

Are you experiencing any physical pain? Yes____No ____

Have you ever received treatment for any of the following medical conditions?

Neurological impairment
Seizure disorder
Visual loss / impairment
Hearing loss / impairment
Dementia
GI disorder
Obesity
Significantly underweight
Cirrhosis
Hepatitis
Heart condition
Hypertension
Asthma
Emphysema
Chronic bronchitis
Tuberculosis / +PPD
Cancer
Thyroid disease
Diabetes
Pregnancy
Irregular menstrual periods
Musculoskeletal condition
HIV / AIDS / Related condition
Other

Family Psychiatric/Medical History: *(*Please list any familial psychiatric or major medical problems, eating disorders, alcohol/substance abuse, and suicide attempts)

____

____

____

Social History*:* (List marriages, divorce, children and any other social relationships. Also any support systems you may have.

____

____

____

Educational/Occupational

Highest Grade Completed: ______

Name of college/university (**if currently enrolled**) ___________________________________

Are you currently employed? If yes, current occupation: ________________________________

Military Veteran: Yes ☐ No ☐ **OR** Military Dependent: Yes ☐ No ☐

Spiritual/Religious Affiliation: ____

____

History of Legal Problems No ☐Yes ☐ (if yes please explain:)

____

____

____

History of trauma*? (To include abuse, domestic violence, witnessing of; and military trauma)*:

No ☐ Yes ☐ (**If yes please explain**):

____

____

What are some of your strengths and weaknesses/challenges?

____

____

____

What would you like to accomplish from your time in therapy?

____

____

Thank you for your cooperation and patience. Our clinician will see you shortly and discuss these and other issues in greater detail and help you develop a treatment plan to effectively deal with these issues.