Wham Counseling, LLC

Adult Questionnaire

Name: ____________________ DOB: ____________ Age: ______ ◯ Male ◯ Female

Who referred you? ____
Problems for which you are seeking therapy: ______________________________

Changes you hope to see from treatment? ______________________________

Seen a therapist or counselor? ◯ No ◯ Yes If yes, specify: ____________________

Treatment History

Have you ever been hospitalized for mental health or alcohol/ substance abuse? ◯ No ◯ Yes
If yes, please specify the facility, approximate dates, as well as reason: ____________________

Does anyone in your family have a history of mental health problems or addictions? ◯ No ◯ Yes
If yes, who and a brief description of the problem: ____________________

Do you use any of the following? ◯ Alcohol ◯Tobacco ◯ Caffeine ◯ Drugs (other than prescribed) ◯ None
If yes, for how long and in what amount: ____________________

Have you ever felt the need to reduce or limit the amount of alcohol or drugs you use? ◯ No ◯Yes
Have others ever expressed concern about your level of use and the effects on you? ◯ No ◯Yes
Have you ever used drugs or alcohol as an "eye-opener" in the morning? ◯ No ◯Yes
Have you ever had guilt about your drinking or drug use? ◯ No ◯Yes
Have you had thoughts of death or harming yourself within the past month? ◯No ◯Yes If yes, how recently? ________
Do you currently have thoughts of death? ◯No ◯ Yes
Have you ever attempted suicide? ◯ No ◯Yes
If yes, when and how: ____________________

Do you ever have thoughts of harming someone else? ◯ No ◯Yes
If yes, whom: ____________________

Medical History

Please list specific medical conditions, procedures, hospitalizations or operations that you have had in the past: ____________

Please list any current physical problems or illnesses that significantly affect your health: ____________

Please list any physicians who are currently treating you: ____________________
Date of last physical exam: ____________________

Please list any current medications (including over the counter medications & supplements) you are taking: ____________

Previous psychiatric medication: ____________________

Social History

Relationship status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

Number of marriages? ______________________________

People living in the same home with you

Name	Relationship	Age

Are there any minor children not living with you? ◯ No ◯ Yes **If yes, please specify:** ______________________________

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Were you raised by your biological parents? ◯ No ◯ Yes **If no, by whom:** ______________________________

Are they living? ◯ No ◯ Yes **If no, cause and age at time of death:** ______________________________

Please list name and ages of your siblings: ______________________________

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Education: ◯ Some High School ◯ GED graduate ◯ High School ◯ Some college ◯ College graduate ◯ Post graduate

If currently working, what is your occupation? ______________ **How long?** ______________

Which of the following legal actions has happened to you? ◯ None ◯ Probation ◯ Parole ◯ Child Custody ◯ DUI

Current charges? ______________________________

Current legal situations? ______________________________

Have you experienced emotional, physical, sexual abuse, rape or domestic violence? ◯ No ◯ Yes

If yes, please specify (if you prefer you may wait to discuss with your therapist): ______________________________

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Please ask me about

- **Mood**
- **Anxiety**
- **Fear**
- **Obsessive thoughts**
- **Sleep patterns**
- **Anger**
- **Judgment and decision making**
- **Troublesome thoughts**
- **Ability to feel close and safe with others**
- **Mental abilities/changes**
- **Risky behavior**
- **Marriage or relationships**
- **Sexuality**
- **Abusive relationship**
- **Childhood issues**
- **Alcohol or substance abuse**
- **Spiritual Beliefs**
- **Body image/ eating**
- **Financial situation**

Signature: ______________________________ **Date:** ______________