LISA K. SCHKLOVEN, LCSW-C, LLC

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NAME: _____ **DOB:** _____

ADULT HEALTH QUESTIONNAIRE

PHYSICIAN		
Physician's/Practice Name:		
Street Address:		
City	State:	Zip:
Physician's Address:		

CURRENT MEDICAL CONDITIONS, INCLUDING ALLERGIES: *Please list any medical conditions for which you currently receive treatment, including allergies.*

Condition	Treatment Dates	Outcome

CURRENT MEDICATIONS: *Please list any medications which you take. Include any prescription and any over- the- counter medications.*

Medication	Dosage	Purpose

HOSPITALIZATIONS: *Please list any hospitalizations and surgeries*

Condition	Treatment Dates	Outcome

CHILDHOOD MEDICAL CONDITIONS: *Please list any medical conditions for which you received treatment as a child, including any hospitalizations.*

Condition	Treatment Dates	Outcome

MENTAL HEALTH CONDITIONS/TREATMENT: *Please complete this section if you have ever received any mental health related services.*

Type of Treatment	Treatment Dates	Provider's Name
Psychiatric Hospitalization: Reason	**Hospitalization Dates**	**Facility Name**

FAMILY MEDICAL/PYSHCIATRIC HISTORY: *Please list any family member with a history of medical/emotional illnesses including chronic physical conditions, depression, alcohol and/or drug problems, eating disorders, medical and/or psychiatric hospitalizations. Please use the back of this page if necessary.*

Name/Gender	Relationship to You	Condition & Treatment (if known)

HABITS AFFECTING GENERAL HEALTH

SMOKING: *Do you currently smoke cigarettes?* ☐ Yes ☐ No

If you currently smoke cigarettes, how often do you smoke and how much?

Have you ever tried to quit? ☐ Yes ☐ No

If you answered yes to the above, how many times have you tried to quit and for how long were you able to refrain from smoking?

DRINKING: *Do you drink alcohol?* ☐ Yes ☐ No

If yes, what do you drink?

How often do you drink?

How much do you drink per week?

Do you have a favorite place where you drink?

Have you ever tried to cut down and/or stop drinking?

How successful were you?

Have you ever felt guilty about your drinking?

Has drinking ever interfered with your ability to work? If so, please explain.

Do you experience blackouts? If so, how often?

Have you ever been charged with DUI? If so, when? What was the outcome?

Have you ever been required to obtain treatment for drinking? If so, please list.

Have you ever considered your alcohol usage to be a problem for you? If so, please explain.

DRUG USE: *Do you use drugs?* ☐ Yes ☐ No
If yes, what do you use?
How often do you use?
Have you ever tried to cut down on or stop using drugs?
How successful were you?
Have you ever felt guilty about your drug use?
Has drug use ever interfered with your ability to work? If so, please explain.
Have you ever been charged with a drug related crime? If so, please explain.
Have you ever been required to obtain treatment for drug use? If so, please list.
Have you ever considered your drug usage to be a problem for you? If so, please explain.

DEPRESSION: *Are you currently feeling depressed?* ☐ Yes ☐ No *If you answered yes, please answer the following:*
How long have you been feeling depressed?
What happens to you when you get depressed?
Have you experienced changes in eating or sleeping habits? If yes, please explain.
Do you feel like hurting yourself? When? How would you do this?

AGGRESSION TOWARD YOURSELF AND OTHERS
Have you ever had thoughts of harming anyone? ☐ Yes ☐ No *If you answered yes, please list dates and who:*
Have you ever gotten in trouble because of temper/violence? ☐ Yes ☐ No *If you answered yes, please explain.*
Does drinking and/or drug use ever lead you to become violent? ☐ Yes ☐ No *If you answered yes, please explain.*
Do you own a gun? ☐ Yes ☐ No *If you answered yes, where do you keep it?*
Have you ever considered harming others with a gun? ☐ Yes ☐ No *If you answered yes, please explain.*

Person completing this form (Please Print): _____

Signature: _____

Date: _____