ADULT HISTORY QUESTIONNAIRE

(Please print all information)

Name: ____ **DOB:** _______________

Social Security Number: ___________________________ **Age:** _______________

Employer: ___________________________ **Occupation:** ________________________

Address: ____

____

Referred By: ____

Reason for Consultation: ____

____

____

Telephone: Day_____________________________ **Evening**_______________________

INSTRUCTIONS: The information on the following pages will help me to better understand you and to facilitate differential diagnosis and treatment planning. You may leave any question blank if you do not wish to answer it. Please feel free to ask any questions which you might have about the Questionnaire.

Please return the completed questionnaire to:

Bruce E. Mapes, Ph.D.
P.O. Box 1028
Exton, PA 19341

Telephone: 610 696-8740
Fax: 610-696-8741

PARENTS

BIOLOGICAL PARENTS:

FATHER: Name ____ Age: ________________

Current residence: City ____________________________ State: ___________________

Occupation: ____ Retired: ___ Yes ___ No

Health: ___ Very Good ___ Good ___ Poor ___ Deceased

Your relationship with your father: ___ Very Good ___ Good ___ Poor

MOTHER: Name ____ Age: _______________

Current residence: City ____________________________ State: ___________________

Occupation: ____ Retired: ___ Yes ___ No

Health: ___ Very Good ___ Good ___ Poor ___ Deceased

Your relationship with your mother: ___ Very Good ___ Good ___ Poor

ADOPTIVE PARENTS:

FATHER: Name ____ Age: ________________

Current residence: City ____________________________ State: ___________________

Occupation: ____ Retired: ___ Yes ___ No

Health: ___ Very Good ___ Good ___ Poor ___ Deceased

Your relationship with your father: ___ Very Good ___ Good ___ Poor

MOTHER: Name ____ Age: __________________

Current residence: City ___________________________ State: _____________________

Occupation: ____ Retired: ___ Yes ___ No

Health: ___ Very Good ___ Good ___ Poor ___ Deceased

Your relationship with your mother: ___ Very Good ___ Good ___ Poor

STEP PARENTS

FATHER: Name ____ Age: ____________________

Current residence: City __________________________ State: ______________________

Occupation: ____ Retired: ___Yes ___No

Health: ___ Very Good ___ Good ___ Poor ___ Deceased

Your relationship with your father: ___ Very Good ___ Good ___ Poor

MOTHER: Name ____ Age: ___________________

Current residence: City ___________________________ State: ______________________

Occupation: ____ Retired: ___Yes ___No

Health: ___ Very Good ___ Good ___ Poor ___ Deceased

Your relationship with your mother: ___ Very Good ___ Good ___ Poor

SIBLINGS: (Please list from oldest to youngest)

Name ______________________________ Age _____ ___ Biological ___ Step ___ Half

Sex: ___ Male ___ Female ___ Living ___ Deceased Marital Status: M S D W

No. Of Children: _______ Occupation: _______________________________________

Residence: City: _____________________ State: _____ Health: ___ Good ___ Poor

Your relationship: ___ Very Good ___ Good ___ Poor

Name ________________________________ Age _____ ___ Biological ___ Step ___ Half

Sex: ___ Male ___ Female ___ Living ___ Deceased Marital Status: M S D W

No. Of Children: _______ Occupation: _______________________________________

Residence: City: _____________________ State: _____ Health: ___ Good ___ Poor

Your relationship: ___ Very Good ___ Good ___ Poor

Name ______________________________ Age _____ ___ Biological ___ Step ___ Half

Sex: ___ Male ___ Female ___ Living ___ Deceased Marital Status: M S D W

No. Of Children: _______ Occupation: _______________________________________

Residence: City: _____________________ State: _____ Health: ___ Good ___ Poor

Your relationship: ___ Very Good ___ Good ___ Poor

Name ___________________________________ Age _____ ___ Biological ___ Step ___ Half

Sex: ___ Male ___ Female ___ Living ___ Deceased Marital Status: M S D W

No. Of Children: _______ Occupation: ____

Residence: City: _______________________ State: ______ Health: ___ Good ___ Poor

Your relationship: ___ Very Good ___ Good ___ Poor

Name ___________________________________ Age _____ ___ Biological ___ Step ___ Half

Sex: ___ Male ___ Female ___ Living ___ Deceased Marital Status: M S D W

No. Of Children: _______ Occupation: ____

Residence: City: _______________________ State: ______ Health: ___ Good ___ Poor

Your relationship: ___ Very Good ___ Good ___ Poor

Name ___________________________________ Age _____ ___ Biological ___ Step ___ Half

Sex: ___ Male ___ Female ___ Living ___ Deceased Marital Status: M S D W

No. Of Children: _______ Occupation: ____

Residence: City: _______________________ State: ______ Health: ___ Good ___ Poor

Your relationship: ___ Very Good ___ Good ___ Poor

Name ___________________________________ Age _____ ___ Biological ___ Step ___ Half

Sex: ___ Male ___ Female ___ Living ___ Deceased Marital Status: M S D W

No. Of Children: _______ Occupation: ____

Residence: City: ___________________________ State: ______ Health: ___ Good ___ Poor

Your relationship: ___ Very Good ___ Good ___ Poor

Name ___________________________________ Age _____ ___ Biological ___ Step ___ Half

Sex: ___ Male ___ Female ___ Living ___ Deceased Marital Status: M S D W

No. Of Children: _______ Occupation: ____

Residence: City: ___________________________ State: ______ Health: ___ Good ___ Poor

Your relationship: ___ Very Good ___ Good ___ Poor

DEVELOPMENTAL HISTORY

During her pregnancy with you, did your mother:

___ Smoke ___ Drink alcohol ___ Use prescribed medications ___ Use other drugs

___ Experience any trauma ___ Have any surgery ___ Have any complications

Was your birth ___ Early ___ Full term ___ Late ___ C-section ___ Breech?

Please check any of the following problems you had as a child:

___ Colic ___ Poor coordination ___ Poor appetite ___ Large appetite ___ Nightmares

___ Vision ___ Hearing ___ Allergies ___ Encopresis ___ Enuresis ___ Hyperactivity

___ Running away ___ Frequent crying ___ Temper tantrums ___ Difficulty separating from parents

___ Excessive fears ___ Depression ___ Excessive anger ___ Frequent moves ___ Trauma

Were you ever abused: ___ Physically ___ Emotionally ___ Sexually?

Please list all significant injuries and/or hospitalizations which you had as a child or adolescent:

How would you describe your childhood and adolescence?

EDUCATIONAL HISTORY

Did you go to nursery school or preschool? ___ Yes ___ No

What elementary school(s) did you attend?

What junior high school(s) or middle school(s) did you attend?

What high school(s) did you attend?

Did you graduate from high school? ___ Yes ___ No When? __________

If not, did you complete your GED? ___ Yes ___ No When? ________

If you did not graduate, what is the highest grade you completed? _________

If you did not graduate, why did you leave school?

Please check any of the following problems or special services you had in school:

___ Reading ___ Math ___ Writing ___ English/language arts ___ Physical education

___ Social studies/history ___ Concentration ___ Hyperactivity ___ Special education

___ Speech therapy ___ Remedial reading ___ Adaptive phys. ed. ___ Conflicts with teachers

___ Conflicts with peers ___ Excessive detentions ___ Suspensions ___ Expulsion ___ Truancy

Please check the extracurricular activities in which you participated in school:

___ Sports ___ Band/orchestra/chorus ___ Clubs ___ School play ___ Student council

___ Worked after school ___ Community activities/organizations

Please describe your fondest memory of school:

What college or trade school did you attend?

Major area of study:

When did you graduate? ____________ Degree: _____

If you did not graduate, why did you leave?

What special honors or recognitions did you receive?

Did you earn a Master's Degree? ___ Yes ___ No When? __________

School ____________________________________ Major ___________________________________

Did you ear a doctorate or professional degree? ___ Yes ___ No When? _______________________

School ____________________________________ Major _________________________________

Please describe any postgraduate courses you have taken:

Please describe any future educational plans which you have:

OCCUPATIONAL HISTORY

Please begin with your first job after completing school

Occupation: ______________________ Dates ______________

Employer ______________________

Reason for leaving ______________________

Occupation: ______________________ Dates ______________

Employer ______________________

Reason for leaving ______________________

Occupation: ______________________ Dates ______________

Employer ______________________

Reason for leaving ______________________

Occupation: ______________________ Dates ______________

Employer ______________________

Reason for leaving ______________________

Occupation: ______________________ Dates ______________

Employer ______________________

Reason for leaving ______________________

Occupation: ______________________ Dates ______________

Employer ______________________

Reason for leaving ______________________

Occupation: ______________________ Dates ______________

Employer ______________________

Reason for leaving ______________________

Occupation: ____ Dates ____________________

Employer ____

Reason for leaving ____

Have any of your jobs involved:

___ Chemical exposure ___ Toxic waste exposure ___ Solvent/paint exposure

___ Radiation exposure ___ Excessive stress ___ Frequent layoffs

Have you experienced any of the following job-related problems?

___ Conflicts with superiors ___ Conflicts with peers ___ Conflicts with your union

___ Suspension Disciplinary action ___ Demotion ___ Absenteeism ___ Frequent travel

___ Referral to your EAP program ___ Legal problems ___ Criminal charges

What are your future occupational or career plans?

MILITARY SERVICE

Were you in the military? ___ Yes ___ No Branch: ____

Dates of service: ___________________ Did you serve overseas? ____________________________

Type of discharge? ___ Honorable ___ Dishonorable ___ General ___ Medical ___ Other

Highest rank earned ________________________ Were you involved in combat? ___ Yes ___ No

Briefly describe your duties:

What special honors or awards did you receive?

Were you the subject of any disciplinary actions? ___ Yes ___ No

Please explain.

LEGAL HISTORY

Have you ever received a ticket for:

___ Speeding ___ Reckless/careless driving ___ DUI

Have you ever been arrested for:

___ Theft ___ Burglary ___ Simple assault ___ Aggravated assault ___ Child abuse

___ Domestic violence ___ Drug related charges ___ Alcohol related charges ___ Trespassing

___ Arson ___ Forgery ___ Fraud ___ Homicide ___ Sexual offense

___ Other misdemeanor ___ Other felony

Have you ever been on probation? ___ Yes ___ No

Have you ever served time in prison? ___ Yes ___ No

Have you ever been on parole? ___ Yes ___ No

Please describe your arrest history:

MARITAL HISTORY

Please complete the following for each legal or common law marriage you have had.

Spouse's name ____ Current age: _________________

___ Common law ___ Legal marriage ___ Deceased ___ Separated/divorced

Strengths of marriage: ____

Weaknesses of marriage: ____

If separated/divorced, Why? ____

Names and ages of children: ____

Names and ages of step-children: ____

Spouse's name ____ Current age: _________________

___ Common law ___ Legal marriage ___ Deceased ___ Separated/divorced

Strengths of marriage: ____

Weaknesses of marriage: ____

If separated/divorced, Why? ____

Names and ages of children: ____

Names and ages of step-children: ____

Spouse's name ____ Current age: _________________

___ Common law ___ Legal marriage ___ Deceased ___ Separated/divorced

Strengths of marriage: ____

Weaknesses of marriage: ____

If separated/divorced, Why? ____

Names and ages of children: ____

Names and ages of step-children: ____

Spouse's name ______________________________ Current age: ____________

___ Common law ___ Legal marriage ___ Deceased ___ Separated/divorced

Strengths of marriage: ______________________________

Weaknesses of marriage: ______________________________

If separated/divorced, Why? ______________________________

Names and ages of children: ______________________________

Names and ages of step-children: ______________________________

Spouse's name ______________________________ Current age: ____________

___ Common law ___ Legal marriage ___ Deceased ___ Separated/divorced

Strengths of marriage: ______________________________

Weaknesses of marriage: ______________________________

If separated/divorced, Why? ______________________________

Names and ages of children: ______________________________

Names and ages of step-children: ______________________________

MEDICAL HISTORY

Please indicate with a checkmark any of the following medical problems which you have had and put a circle around any medical problem which a blood relative has had.

Measles

German Measles

Mumps

Chicken pox

Whooping cough

Diphtheria

Scarlet fever

Rheumatic fever

Malaria

Headaches

Tiredness

Weakness

Meningitis

Encephalitis

Hemophilia

Clotting problems

Lung disease

Muscle disease

Joint disease

Parkinson's Disease

Epilepsy

Coma

Tuberculosis

Polio

Fainting spells

High Blood Pressure

Stroke

Multiple Sclerosis

Alzheimer's Disease

Dementia

Huntington's Chorea

Hypoactive thyroid

Hyperactive thyroid

Heart Disease

Lupus

Cancer

Sexually transmitted disease

HIV/AIDS

Anemia

Chest Pains

Heart Attack

Sunstroke

Anoxia

Near death experience

Altitude sickness

electrical shock

head injury

Loss of consciousness

Paralysis

Vision problems

Hearing problems

Loss of sense of touch

Loss of sense of taste

Feelings of tingling and/or numbness

Eczema / hives

Jaundice

Hepatitis

Kidney problems

Stomach problems

Diabetes

Lead poisoning

Toxic chemical exposure

Pesticide exposure

Carbon monoxide poisoning

Nutritional problems

Muscle twitching or spasms

Tremors

Problems dropping things

Problems with getting lost

Memory problems

Confusing right and left

Back problems

Arthritis

Irritable bowel

Sinusitis

Sleep apnea

Loss of balance

Vertigo

Who is your family doctor? ____

When did you last see your physician and why?

Please list any specialists you have seen during the past five years and the reason for each visit:

Please list any and all medications taken during the past five years:

Please provide any additional medical history which you feel is important.

SUBSTANCE USE HISTORY

Please indicate the extent of your current and past use of the following substances:

Substance	Experimental	Recreational	Abuse
Alcohol			
Downers			
Speed			
Narcotics			
Cocaine			
PCP / LSD			
Mushrooms, Mescaline			
Pot			
Paint / Solvents			
Cleaning Fluids			
Laughing Gas			
Ecstasy			
Heroin			
Designer Drugs			
Other			

Please describe any educational, legal, financial, or other difficulties resulting from substance use:

Please describe any substance abuse treatment which you have had:

SYMPTOM CHECKLIST

Please check any of the following symptoms which you have experienced in the past and circle any which you currently experience:

Difficulty falling asleep

Frequent awakening

Waking up early

Excessive sleep

Insomnia

Increased appetite

Decreased appetite

Weight gain

Weight loss

Binging

Purging

Poor concentration

Suicidal thoughts

Homicidal thoughts

Attempted suicide

Periods where you lose time

Periods where you forget where you are

Trouble with "Common sense"

Sadness

Depression

Anger control

Mood swings

Excessive worry

Excessive guilt

Loss of interest in pleasurable activities

Low energy

Too much energy

Low self-esteem

Feelings of hopelessness

Feelings of helplessness

Crying spells

Rituals

Nightmares

Low frustration tolerance

Daydreaming

Excessive fear

Fear of leaving home

Fear of crowded places

Easily embar-rassed

Trouble sitting still

Impulsiveness

Poor organization

Tics

Difficulty finishing things

Easily bored

Need for stimulation

Hallucinations

Delusions

Recurring thoughts

Difficulty trusting others

Feeling others want to harm you

Feeling others know your thoughts

Excessive spending

Clammy skin

Racing heart

Tightness in chest

Difficulty breathing

Panic attacks

Forgetting the year

Forgetting the day

Forgetting where you put things

Forgetting people's names

Forgetting words

Difficulty making decisions

Sexual dysfunction

Cross dressing

Exhibitionism

Sexual sadism

Sexual masochism

Bondage

Voyeurism

Unusual sexual interests

Homosexuality

Troubling thoughts

Fear of losing control

Excessive gambling

Lack of remorse

Firesetting

Cruelty to animals

Domestic violence

Child abuse

Self-mutilation

Have you ever had outpatient psychotherapy or counseling? ___ Yes ___ No

Have you ever had inpatient treatment? ___ Yes ___ No

Please list the dates of psychological treatment and the name of the therapist(s):

Please list all psychotropic medications which you have taken:

Please explain what you hope will be the outcome of your psychological consultation.