ADULT CLINICAL QUESTIONNAIRE

NAME:_______________________________________ DATE OF BIRTH: ___________________________
AGE: __________________ MARITAL STATUS: ______________________________
CHILDREN AND AGES: ____
ARE YOU WORKING: YES_____ NO ______ RETIRED ______ OCCUPATION ______________________
ARE YOU RECEIVING SSD DISABILITY OR HAVE YOU APPLIED FOR SSD ___________________________
WHO DO YOU LIVE WITH? __________________________________

REASON FOR COMING TO THIS CLINIC:
____
____

NAME OF CURRENT THERAPIST: __________________________________ PHONE NUMBER: ___________

CURRENT PSYCHIATRIC MEDICATIONS:

Name of medication	Dose and times	When started	Concerns

PAST PSYCHIATRIC MEDICATIONS:

Name of medication	Dose and times a day	When and for how long	Cocerns

Have you had any allergic reactions to medications: NO ____ YES ____
If yes please describe: ____

At what age did you first seek treatment for your mental health issues: ____________________

Have you ever been hospitalized for mental health issues: YES _____ NO ______
When and which hospitals?____
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Are you currently in counseling or have you had counseling in the past: YES_____ NO______

FAMILY MENTAL HEALTH HISTORY: Has anyone in your family being treated for mental health problems? YES______ NO______ Please describe _____________________________________
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