HTTPS://BALANCEANDPOTENTIAL.COM
678-644-0039

ADULT QUESTIONNAIRE

If there are any questions you prefer not to answer, just leave them blank.

REFERRAL INFORMATION

Who referred you to Balance & Potential Inc? (Name/Location) _____

Please describe the Reason for Referral: _____

_____

_____

Do we have your permission to contact them? ❑Yes ❑No

Person(s) filling out this form_____ Relationship to Client_____

1. Personal Information

Client's Name_____

(First) (Middle) (Last)

Name you prefer to be called_____

Date of Birth_____ Age_____ Gender_____ Ethnicity/Race_____

Home Address_____ County_____

(street) (apt. no.)

_____ Home Phone #_____

(city) (state) (zip code)

How long have you lived at this address? _____

Cell Phone #_____ Email Address_____

Alternate number_____ Is this a home, cell, or work number? _____

May we leave messages on voice mail at these numbers? ❑Yes ❑No May we contact you by e-mail? ❑Yes ❑No

Emergency Contact Name: _____ Relationship: _____ Contact #: _____

2. Emotional/Behavioral Symptoms Checklist (Rate the intensity of symptoms that are currently present)**:**

0=This symptom is not present at this time
1=This symptom is present, somewhat bothersome, but not enough to be a problem
2=The symptom is present, bothersome, and affects quality of life, but I am able to function
3=This symptom makes moderate impact on quality of life and/or day-to-day functioning
4=This symptom makes significant impact on quality of life and day-to-day functioning
5=This symptom makes serious impact on quality of life and interferes with day-to-day functioning

Symptom	Severity	Symptom	Severity	Symptom	Severity
Alcohol problems		Suicidal thoughts		Sadness	
Drug problems		Absence from work		Low self-esteem	
Social/relationship issues		Stealing		Thoughts of harming self	
Academic problems		Inattention		Depressed mood	
Trauma or abuse		Compulsions or obsessions		Problems falling asleep	
Physical aggression		Fidgeting/squirming		Problems staying asleep	
Gambling		Hyperactivity		Grief/bereavement	
Mania or hypomania		Impulsivity		Poor appetite	
Racing thoughts		Compulsive behavior		Weight loss	
Verbal aggression		Failing to finish things		Isolation/loneliness	
Threatening others		Difficulty working quietly		Eating too little	
Losing temper easily		Talking excessively		Eating too much	
Arguing		Memory problems		Weight gain	
Oppositional		Tics or twitches		Binge eating	
Defiance		Forgetfulness		Purging	
Annoying others on purpose		Blurting out/interrupting		Trouble concentrating	
Easily annoyed by others		Time management problem		Hearing voices not there	
Anger/irritability		Losing things		Seeing things not there	
Destructive to property		Poor organization skills		Shy/timid	
Lying (to avoid trouble)		Easily distracted		Anxious/fearful	
Nightmares		Following directions		Panic attacks	
Problems with self care		Low energy/fatigue		Physical pain	
Dissociation		Unpredictable moods		Heart pounding/racing	
Frequent illness		Homicidal thoughts		Sexual behavior problems	
Financial problems		Nervous habits		Cruel to animals	
Legal problems		Adjustment problems		Fire setting	
Addiction to _____		Personality problems		Other:	

Please describe any of the following (or other) concerns: _____

_____

_____

What is the main concern that led you to coming here? _____

_____

_____

How long have you had this concern?_____

_____

How do you handle stress? _____

_____

3. Mental Health Treatment History:

Have you ever been hospitalized for psychological or emotional problems? ❑Yes ❑No

If yes, please describe below and provide dates/names of treatment center(s).

_____

_____

_____

Are you currently receiving outpatient mental health services? ❑Yes ❑No If yes, please write below.

Name of Provider/Treatment Center_____ Date of initial service _____

Which outpatient support people or other agencies have you seen? (psychologists, psychiatrists, therapists, counselors, social workers, mental health centers, clergy people, etc.)?

Name and Agency	Phone Number	Dates & Frequency

Do you currently have a mental health diagnosis? ❑Yes ❑No If yes, please specify below.

_____

_____

In the past, were you ever diagnosed with a mental health condition? ❑Yes ❑No If yes, please specify below.

_____

_____

Are you currently taking any medications for mental health reasons? ❑Yes ❑No If yes, please specify below.

Medications & Dosage	Dates & Frequency	Prescribing Physician

Have you ever been recommended or prescribed medications for mental health reasons? ❑Yes ❑No If yes, please specify below.

Medications & Dosage	Dates & Frequency	Prescribing Physician

Any history of suicidal thoughts? ❑Yes ❑No If yes, for how long? _____

Date of most recent suicidal thought: _____

Any history of suicidal attempts? ❑Yes ❑No

Any history of homicidal thoughts? ❑Yes ❑No If yes, for how long? _____

Date of most recent homicidal thought: _____

Any history of homicidal attempts? ❑Yes ❑No

Any history of self-injurious behaviors (i.e., cutting, biting, restricted eating)? ❑Yes ❑No If yes, what kind?

_____

_____

Is there a family history of mental illness? ❑Yes ❑No If yes, specify below.

Relative	**Which side of the family (Please check)**	**Mental Health Condition**
_____	❑Maternal ❑Paternal	_____
_____	❑Maternal ❑Paternal	_____
_____	❑Maternal ❑Paternal	_____
_____	❑Maternal ❑Paternal	_____
_____	❑Maternal ❑Paternal	_____

Have you ever experienced any history of physical, verbal, emotional, sexual, or mental abuse? ❑Yes ❑No

4. Medical and Health History

Do you have a primary care provider? ❑Yes ❑No If yes, who is your provider? _____

Where is your provider located? _____

Address _____ Phone number _____

Date of most recent physical examination: _____/_____/_____

Date of most recent dental examination: _____/_____/_____

Date of most recent vision examination: _____/_____/_____

Date of most recent hearing examination: _____/_____/_____

Which allergies do you have? ❑None _____

Are your immunizations up-to-date? ❑Yes ❑No

Do you wear eyeglasses or contact lenses? ❑Yes ❑No

Do you have any trouble with your hearing? ❑Yes ❑No

Have you ever been diagnosed with a physical/medical disability? ❑Yes ❑No If yes, please specify below.

_____

_____

Are you currently being treated for any physical or medical problems? ❑Yes ❑No If yes, please specify below.

Physical or Medical Conditions	Physician treating you	How long have you had this problem?

List any medications you are currently taking, the dosage, the prescribing physician, & the reason for the medication.

Medication & Dosage	Physician	Reason

Have you had any recent health or physical changes? ❑Yes ❑No If yes, please specify below.

_____

_____

5. Developmental History

Do you have any siblings? ❑Yes ❑No If yes, how many brothers? _____ How many sisters? _____

What was your birth order? _____ of _____ total children.

Did you experience any developmental delays, injuries, hospitalizations, led exposure/poisonings or surgeries during your childhood? ❑Yes ❑No If yes, please indicate: _____

_____

6. Substance Use History

Have you ever used alcohol regularly (2 or more drinks per week)? ❑Yes ❑No If yes, age at first use? _____

Do you currently consume alcohol? ❑Yes ❑No If yes, please indicate (beer, wine, liquor, etc.):_____

How many drinks do you have in a setting?_____

How often do you have an alcoholic beverage? _____

Have you ever smoked cigarettes or used tobacco products? ❑Yes ❑No If yes, age at first use? _____

Do you currently smoke cigarettes or use tobacco products? ❑Yes ❑No If yes, please indicate (cigars, cigarettes, chewing tobacco, etc.): _____

How many packs do you smoke? _____

How often do you smoke cigarettes or use other tobacco products? _____

Have you ever used any prescription drugs or over-the-counter (OTC) medicines to get high? ❑Yes ❑No

If Yes, age at first use? _____ Please specify the substances used: _____

Are you currently using prescription drugs or over-the-counter medicines to get high? ❑Yes ❑No If yes, how much do you use? _____ How often do you use?_____

Have you ever used any illegal drugs? ❑Yes ❑No If yes, please complete the following.

Substance	Age of First Use	Amount/Frequency	Last date of use
❑ Marijuana or Hashish	_____	_____	_____
❑ "Spice"	_____	_____	_____
❑ Cocaine/Crack	_____	_____	_____
❑ Ecstasy/MDMA/or/Molly	_____	_____	_____
❑ Methamphetamine	_____	_____	_____
❑ Heroin	_____	_____	_____
❑ Opium	_____	_____	_____
❑ Psilocybin Mushrooms	_____	_____	_____
❑ LSD	_____	_____	_____
❑ PCP/Angel Dust	_____	_____	_____
❑ Abuse of Rx pain killers	_____	_____	_____
❑ Steroids	_____	_____	_____
❑ Huffing/Inhalants	_____	_____	_____
❑ Other	_____	_____	_____
❑ Other	_____	_____	_____

How did you use drugs (orally, IV, nasal, inhale, etc.)? _____

Have you ever experienced any of the following? If yes, please check below:
❑Lost job because of drinking or drug use ❑Missed work because of drinking or drug use

❑Fighting because of drinking or drug use ❑Lost relationship because of drinking or drug use ❑DUI/DWI

❑Licensed suspended/revoked

Have you ever received any outpatient, inpatient, medication-assisted therapy, or rehabilitation substance use treatment? ❑ Yes ❑No If yes, please indicate below:

Name and Agency	Phone Number	Dates & Frequency
_____	_____	_____

Is there a family history of substance abuse? ❑Yes ❑No If yes, specify below.

Relative	Which side of the family (Please check)	Substance Dependence
_____	❑Maternal ❑Paternal	_____
_____	❑Maternal ❑Paternal	_____
_____	❑Maternal ❑Paternal	_____
_____	❑Maternal ❑Paternal	_____
_____	❑Maternal ❑Paternal	_____

7. Family History

What is your marital status: ❑Single ❑Married ❑Separated ❑Divorced

❑Widowed ❑Never Married & Separated ❑Not Married & Living Together

Who raised you?_____

Where were you born? _____ Where were you raised?_____

_____

Were you ever adopted? or placed in foster care? ❑ Yes ❑No

What work did your mother do?_____ Mother is ❑Living ❑Deceased

What work did your father do?_____ Father is ❑Living ❑Deceased

Have you or any member of your household experienced any of the following the past five (5) years? Please give approximate dates and describe.

❑ Death or serious illness of loved one ❑Unemployment ❑ Change or promotion ❑Surgery

❑ Family move ❑Divorce ❑Housing ❑Poverty/Financial ❑Natural disasters

_____

List any people with whom you now live (include all family members, step-family, non-relatives, adults and children...)

✓Check Yes if Now in home.

Name	Age	Relationship	Quality of Relationship	Now in home?
_____	_____	_____	❑Good ❑Fair ❑Poor	❑Yes
_____	_____	_____	❑Good ❑Fair ❑Poor	❑Yes
_____	_____	_____	❑Good ❑Fair ❑Poor	❑Yes
_____	_____	_____	❑Good ❑Fair ❑Poor	❑Yes
_____	_____	_____	❑Good ❑Fair ❑Poor	❑Yes

List any children you may have who are not currently living in your home.

Name	Age	Relationship to You
_____	_____	_____

8. Social History

How would you describe yourself in your peer/social/family relationships? _____

_____

_____

How do your peers/family/coworkers describe you? _____

_____

_____

Do you enjoy spending time with others? ❑Yes ❑No If yes, with whom? _____

_____

How often do you enjoy socializing with others?_____

Do you belong to any social groups (volunteer organizations, religious groups, team sports, etc.)?

_____

Do you have a religion/faith/spirituality that you identify with? ❑Yes ❑No If yes, describe below.

_____

Are there any religious or cultural factors that may impact your treatment? ❑Yes ❑No If yes, please describe:

_____

What are your interests and hobbies? _____

_____

What do you spend time on and enjoy doing?

_____

How do you express affection?_____

Do you have any problems relating with others? Please describe._____

_____

9. Educational History

What is the highest level of education you completed?

❑Less than high school diploma (>12 yrs) ❑High School Diploma ❑GED ❑Technical Certificate/Diploma

❑Associates Degree ❑Bachelor's Degree ❑Master's Degree

❑Professional Degree (e.g. J.D/MD/DDS/DO, etc.) ❑Doctoral Degree (e.g. PhD, PsyD)

❑Some College (indicate years/semesters attended): _____

Field of Study/Major: _____

Please list the schools you have attended, starting with the most recent first:

School	Grade Levels	Dates	Any Special Ed. Services
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What grades did you typically earn?_____

Did you ever receive psychological testing for educational purposes? ❑Yes ❑No If yes, describe (reason, findings – if known): _____

10. Work History

Have you ever participated in a vocational program? ❑Yes ❑No

Are you currently employed? ❑Yes ❑No If yes, what is your primary occupation? _____

Current employer: _____Position:_____ Hours per week: _____

At what age did you begin working full-time (if applicable)? _____

Have you ever lost a job? ❑Yes ❑No If yes, what was the reason (fired, resigned, lay-off, etc.)? _____

_____

Do you have any military experience? ❑Yes ❑No If yes, please describe: _____

_____

11. Legal History

Have you had any legal problems in the past? ❑Yes ❑No If yes, please describe any history of legal involvement, DUI/DWI, probation, jail time, or imprisonment you may have had below.

_____

_____

Do you currently have any legal problems? ❑Yes ❑No If yes, please describe below.

_____

_____

Are you currently on probation? ❑Yes ❑No If yes, who is your probation officer? _____

Do you have an open case with DFCS? ❑Yes ❑No

12. ADDITIONAL INFORMATION

Briefly describe anything else you believe would be important for me to know about you_____

_____

What would you describe are your strengths?_____

_____

_____

What are your goals for your therapy/assessment?

_____

_____

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