DELTA FAMILY CLINIC SOUTH, P.C.
ADULT PSYCHOSOCIAL QUESTIONNAIRE

Name: ____ **DOB**: __________ **Date:** __________
Emergency Contact Name________________________________ Relationship to Patient______________
Home Phone: (____)____-_______ Work Phone: (____)____-_______ Pager: (____)____-_____________

- Please note all **bolded** items must be filled out, including the relevant information associated with each statement.

A. FAMILY OF ORIGIN

1. Briefly describe your biological parents, your relationship to them, and whether or not they are living:
____
____
____

2. How did your parents get along with each other? ____________________________________
____
____

3. **Who raised you as a child? (Please check all that apply)**
☐ Biological Mother ☐ Biological Father ☐ Other, as follows_______________________

4. **List all siblings by name, age, and sex:**
____
____
____

5. **Briefly describe the kind of living situation you grew up in:** ________________________
____
____

6. What is your cultural/ethnic background? ______________________________________

7. Spiritual/religious orientation in family of origin: ________________________________

8. **Have there been any of the following kinds of problems with any of your blood relatives?**

Severe temper tantrums or mood problems?	☐ No	☐ Yes
Mental Illness?	☐ No	☐ Yes
Problems with alcohol or other drug use?	☐ No	☐ Yes
Physical or sexual abuse?	☐ No	☐ Yes
Criminal behavior?	☐ No	☐ Yes
Homicidal or suicidal behavior?	☐ No	☐ Yes

9. Briefly describe any yes responses, relationship of person to you, and/or bring to the attention of your doctor or therapist to discuss: ____
____
____
____

10. Describe your family's beliefs/attitudes towards alcohol/drug usage: ______________________
____

B. PERSONAL BACKGROUND

11. **Any serious problems or unusual circumstances with your birth?** ☐ No ☐ Yes, as follows: ____
____
____

12. **Any special problems or challenges you faced growing up as a child?** ☐ No ☐ Yes, as follows:
____
____

13. How did you do in school? ____

14. **Highest grade or degree completed?** ____

15. **Any time in the military?** ☐ No ☐ Yes, as follows ____

16. **Are you currently employed?** ☐ No, last employed ____
Month Year
☐ Yes, as follows____
____

17. **Marital Status (check all that apply):**

☐ Never Married	☐ Married	☐ Divorced
☐ Living with someone	☐ Separated	☐ Widowed

18. **List all children (including stepchildren):**

NAME	AGE	LIVING WITH YOU	NOT LIVING WITH YOU

19. **What is your current living situation?** ____

20. What are your current spiritual/religious beliefs? ____
☐ Active ☐ Inactive

21. **Do you have any money problems?** ☐ No ☐ Yes, as follows ____
____

22. **Do you have any legal problems?** ☐ No ☐ Yes, as follows ____
____

23. **What do you do for recreation or as a hobby? Describe recreational interests or hobbies:**
____
____

24. **Check all that have occurred at any time:**

☐ AIDS/HIV	☐ Dental Problems	☐ Rheumatic Fever	☐ Anemia
☐ Glaucoma	☐ Seizure	☐ Arthritis	☐ Heart Disease
☐ Sinusitis/ Hay Fever	☐ Asthma	☐ Kidney Disease	☐ Thyroid Problems
☐ Bronchitis	☐ Kidney Disease	☐ Tonsillitis	☐ Cancer/Tumor
☐ Measles	☐ Tuberculosis	☐ Diabetes – Insulin?	☐ Mononucleosis
☐ Venereal Disease: Treated?	☐ Pneumonia	☐ Blood Transfusion	☐ Chicken Pox
☐ Abuse: Physical, Sexual, Verbal	☐ Loss of Consciousness	☐ Blows to the head	☐ Meningitis
☐ Encephalitis	☐ Prolonged fevers	☐ Stroke	☐ Other____________
☐Gynecological problems	☐ Pregnancy		

25. **Check all that are problem areas:**

☐ Abnormal Pain	☐ Dizziness	☐ Headaches	☐ Sleep Problems
☐ Bed Wetting	☐ Ear Infection	☐ Hearing Problems	☐ Weight Loss
☐ Breathing Problems	☐ Tics or Twitching	☐ Eye/Vision Problems	☐ Weight Gain
☐ Chest Pain	☐ Fainting Spells	☐ Nausea	☐ Vomiting
☐ Chronic Pain	☐ Fatigue	☐ Nose Bleeds	☐ Hot Flashes
☐ Constipation/Diarrhea	☐ Frequent Urination	☐ Other Bleeding	☐ Heat/Cold Sensitivity
☐ Sore Throat	☐ Prostrate		

26. Explain in detail the items checked under #24 and #25 (frequency, severity, etc.): _________________

____
____
____
____

27. **Are you currently taking any prescribed medications(s)?** ☐ No ☐ Yes If yes, please describe the type, frequency and reason: ____

____
____
____
____

28. Please list any over-the-counter drugs taken regularly in the last six months (type, frequency, reason):

____
____
____

29. Are you allergic to any medication(s)? ☐ No ☐ Yes If yes, please explain:____________________

____
____

30. **List any operation, medical procedures, or hospitalizations for medical problems:** ___________

____
____
____

31. Date of last physical examination: ____

32. Name of Primary Care Physician:___________________________ Office Location:______________

Patient Name: ____ DOB: _________________

33. **Are you currently under the care of a physician for any active medical problems at this time?**
 No Yes, as follows: ____
____

C. SUBSTANCE USE ASSESSMENT

34. **Have any of your (blood) relatives have what you would call a significant drinking or drug use problem – one that did or should have led to treatment?** Yes No If no, skip to question #37 and continue. If yes, complete the chart below and questions that follow:

Describe the alcohol/drug problems of others in your family, past and present. Also describe Treatment and recovery experience:

RELATIVE (Specify maternal or paternal where relevant)	ALCOHOL/DRUG (Indicate type)	TREATMENT/RECOVERY

35. How has alcohol/drug use affected your family and their social relationships over the past year?

36. How have you been affected by your family's use of alcohol/drugs (emotionally, physically, legally) in the past and present?

37. **How many drinks containing alcohol do you have on a typical day when you are drinking?**

 0 1 or 2 3 or 4 5 or 6 7 to 9 10 or more

38. **How often do you drink the amounts checked above: ________________**

39. **How often do you have six or more drinks (four or more drinks for women) on one occasion?**

 Never Less than monthly Monthly Weekly Daily, or almost daily

40. **Do you now, or have you ever had a problem with alcohol or drugs?** Yes No If no, skip to question #50. If yes, complete the following chart (question #42).

41. **Has anyone else ever said you have a problem with alcohol or drugs?** Yes No If no, skip to question #50. If yes, complete the following chart (question #42).

If you answered yes to questions 40 or 41 above, complete the following chart. If you answered no, proceed to question #50.

42. SUBSTANCE USAGE HISTORY	Ever used? If yes, age of first use:	Method of Use: (injected, Inhaled, Ingested, Snorted)	Age of onset of regular use:	Date/Age last used:	Amount of money spent per week on substance:	Amount used in last 30 days:	Amount used in the last 48 hours:
Alcohol: Beer, wine, liquor, mixed drinks, coolers:							
Sedatives-hypnotics-tranquilizers: Seconal, Valium, Xanax, Librium, Barbiturates, Miltown, Ativan, Dalmanc, Halcion, Restoril, Reds Yellos, Placidyl, Klonopin, Phenergan, Phenobarbital, Tuinal, Nembital, Quaalude, or other:							
Cannabis: Marijuana, Hashish, Liquid THC, or other:							
Stimulants: Amphetamine, Speed, Crystal Meth (Crank), Dexedrine, Ritalin, Ice, Black Beauties, Preludin (Bam), crossroads, or other:							
Cocaine: Freebase, Crack, "Speedball," Powder, or other:							
Opioids: Heroin, Opium, Morphine, Methadone, Darvon, Codeine, Percodan, Demerol, Dilaudid, Cough Syrup w/ codeine, Dolophine, Tylox, Tylenol #3 or #4, Pantapon, or other:							
Hallucinogens/PCP: LSD (Window pane, Acid, Microdot), Mescalline, Peyote, Psilocybin, STP, Mushrooms, PCP (Angel dust, Flakes, Greens), Ecstasy, MDMA, MDA, or other:							
Other: Steroids, Glue, Paint, Nitrous Oxide (Laughing gas), Amyl or Butyl Nitrate (poppers, rush), Nonprescription sleep or diet pills, Clonidine, Elavil, Sinequan, Excedrin, NoDoz, Dexatrim, Caffedrine, Quick-Pep, Vivarin, or other:							

43. Describe when, where and with whom you typically drink or use drugs:

44. Describe any changes in the pattern of your usage other the years. Specify changes in amounts, types of alcohol or drugs, periods of abstinence:

45. How has your alcohol or drug use affected your family and friends in the past and present?

46. What do you think about your past and current alcohol or drug use?

47. What are your preferred substances (specific drugs and/or alcohol)? Rank in order.
1________________________ 3________________________

2________________________ 4__________________________

48. Alcohol/Drug Related Problems/Withdrawal Symptoms Checklist:

PHYSICAL	EMOTIONAL	BEHAVIORAL
____ Blackouts	_____ Depression	_____ A.M. Use
____ Memory Problems	_____ Confusion	_____ Sneaking
____ Tremors/Shakes	_____ Concentration Problems	_____ Gulping
____ Muscle aches	_____ Anxiety of Nervousness	_____ Loss of control
____ Runny eyes/nose	_____ Irritability/Restlessness	_____ Relief use
____ Large pupils, hair standing on end, or sweating	_____ Hostile/Aggressiveness	_____ Impulsive use
____ Seizures	_____ Mood Swings	_____ Use less than before
____ DTs	_____ Impulsivity	_____ Use more than before
____ Fatigue	_____ Euphoria	_____Use despite negative consequences
____ Fever	_____ Relaxation	_____Associate with using friends
____ Hallucinations	_____ Extreme Jealousy	_____ Plan activities around use
____ Heart racing	_____ Paranoia	_____ Loss of interest in activities
____ Overdose	_____ Vivid, unpleasant dreams	_____ Change in work/school performance
____ Appetite Problems	_____ Feelings of Guilt/Shame	_____ Work/school lateness or absenteeism
____ Nausea/Vomiting	_____ Suicidal Thoughts	_____ Job loss due to use
____ Diarrhea	_____ Homicidal Thoughts	_____ Frequent arguments
____ Sleep Problems	_____ Other	_____ Separation/divorce due to use
____ Sexual Problems		_____ Financial problems
____ Injuries		_____ Legal problems
____ Accidents		_____ Physically abusive to self
____ Other Medical Problems		_____ Physically abusive to others
		_____ Suicide attempt(s)
		_____ Homicide attempt(s)

49. If any of the above are checked off, describe: ____

____

____

List past treatment involvement: (when, where, successful?):__________________________________

____

D. MENTAL HEALTH ASSESSMENT:

50. **The best part of your youth was:** ____

____

____

51. **The worst part of your youth was:** ____

____

____

52. **Do you experience mood cycling?** _________ If yes, explain: ______________________________

____

53. **Do you experience mood changes without the presence of precipitants?** ____________ If yes, explain: ____

54. Do you have any special concerns or problems getting along with your children, parents, coworkers, spouse, or significant others? ☐ No ☐ Yes, as follows: ________________________________

____

____

____

Patient Name: ____ DOB: ________________

55. What do you consider your:

STRENGTHS	WEAKNESSES
______________________	______________________
______________________	______________________
______________________	______________________

56. **Rank the severity of these symptoms most commonly felt in the week prior to this appointment.**
0 = No Problem, 10 = Highest Severity

Appetite/ Eating	0	1	2	3	4	5	6	7	8	9	10
Sleep	0	1	2	3	4	5	6	7	8	9	10
Sexual Activity	0	1	2	3	4	5	6	7	8	9	10
Sexuality	0	1	2	3	4	5	6	7	8	9	10
Energy Level	0	1	2	3	4	5	6	7	8	9	10
Physical/Verbal/Sexual Abuse	0	1	2	3	4	5	6	7	8	9	10
Temper Tantrums	0	1	2	3	4	5	6	7	8	9	10
Anxiety, Fearfulness	0	1	2	3	4	5	6	7	8	9	10
Depression, Sadness	0	1	2	3	4	5	6	7	8	9	10
Confusion, Indecision	0	1	2	3	4	5	6	7	8	9	10
Anger, Frustration	0	1	2	3	4	5	6	7	8	9	10
Feelings of Inadequacy, Guilt	0	1	2	3	4	5	6	7	8	9	10
Loneliness	0	1	2	3	4	5	6	7	8	9	10
Thoughts of harming (self, others, by others)	0	1	2	3	4	5	6	7	8	9	10
Other: ________________	0	1	2	3	4	5	6	7	8	9	10

Comments: ____
____
____

57. **Please circle any additional problems that pertain to you:**

Decision Making	Legal Matters	Nightmares	Pain
Shyness	Divorce	Stress	Marriage
Separation	Education	Headaches	Children
Drug Abuse	Health Problems	Memory	Finances
Alcohol Use	Bowel Trouble	Friends	Ambition
Fear	Stomach Trouble	Concentration	Career Choices
Relaxation	Self Control	Thoughts	Work

58. Please list any friends or family members who you think will be supportive of your treatment.
Name of person(s):

59. What else would you like to tell us or think we should know about you? ______________________
____

______________________________________ ______________________________
Patient Signature Date

______________________________________ ______________________________
Reviewing Clinician Signature Credentials Date

Patient Name: ________________________________ DOB: ________________