

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):**

<u>NAME</u>	<u>AGE</u>	<u>LIVING WITH YOU</u>	<u>NOT LIVING WITH YOU</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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:**

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

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

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

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

27. **Have you ever been abused, abandoned, neglected, or exploited in any way? Yes / No If yes, please explain:** _____

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: _____

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32. Name of Primary Care Physician: _____ Office Location: _____
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
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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:
<u>Alcohol:</u> Beer, wine, liquor, mixed drinks, coolers:							
<u>Sedatives-hypnotics-tranquilizers:</u> Seconal, Valium, Xanax, Librium, Barbiturates, Miltown, Ativan, Dalmanc, Halcion, Restoril, Reds Yellos, Placidyl, Klonopin, Phenergan, Phenobarbital, Tuinal, Nembital, Quaalude, or other:							
<u>Cannabis:</u> Marijuana, Hashish, Liquid THC, or other:							
<u>Stimulants:</u> Amphetamine, Speed, Crystal Meth (Crank), Dexedrine, Ritalin, Ice, Black Beauties, Preludin (Bam), crossroads, or other:							
<u>Cocaine:</u> Freebase, Crack, "Speedball," Powder, or other:							
<u>Opioids:</u> Heroin, Opium, Morphine, Methadone, Darvon, Codeine, Percodan, Demerol, Dilaudid, Cough Syrup w/ codeine, Dolophine, Tylox, Tylenol #3 or #4, Pantapone, or other:							
<u>Hallucinogens/PCP:</u> LSD (Window pane, Acid, Microdot), Mescaline, Peyote, Psilocybin, STP, Mushrooms, PCP (Angel dust, Flakes, Greens), Ecstasy, MDMA, MDA, or other:							
<u>Other:</u> 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?

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

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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: _____