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	□ Prostate		

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: _____

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 had 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, explain and complete question #42: _____
_____
_____.

42. Substance Use History

If yes to #41, please circle any of the following substances used in your lifetime and fill out the corresponding information:

Alcohol: Beer Wine Liquor Mixed Drinks Cocktails Coolers

If yes, age of first use:	Method of Use: (injected, Inhaled, Ingested, Snorted)	Date/Age last used:	Amount used in last 30 days:	Amount used in the last 48 hours:

Sedatives-Hypnotics-Tranquilizers: Seconal Valium Xanax Librium Barbiturates Miltown Dalmanc Halcion Restoril Reds Yellos Placidyl Klonopin Phenergan Phenobarbital Tuinal Nembital Quaalude Other: _____

If yes, age of first use:	Method of Use: (injected, Inhaled, Ingested, Snorted)	Date/Age last used:	Amount used in last 30 days:	Amount used in the last 48 hours:

Cannabis: Marijuana Hashish Liquid THC Concentrates Other: _____

If yes, age of first use:	Method of Use: (injected, Inhaled, Ingested, Snorted)	Date/Age last used:	Amount used in last 30 days:	Amount used in the last 48 hours:

Stimulants: Amphetamine Speed Crystal Meth (Crank) Dexedrine Ritalin Ice Black Beauties Preludin (Bam) Crossroads Other: _____

If yes, age of first use:	Method of Use: (injected, Inhaled, Ingested, Snorted)	Date/Age last used:	Amount used in last 30 days:	Amount used in the last 48 hours:

Opioids: Heroin Opium Morphine Methadone Darvon Codeine Percodan Demerol Dilaudid Dolophine Cough Syrup With Codeine Tylox Tylenol #3 or #4 Pantapon Other: _____

If yes, age of first use:	Method of Use: (injected, Inhaled, Ingested, Snorted)	Date/Age last used:	Amount used in last 30 days:	Amount used in the last 48 hours:

Hallucinogens/PCP: LSD (Window Pane, Acid, Microdot) Mescaline Peyote Psilocybin STP Mushrooms Ecstasy PCP (Angel Dust, Flakes, Greens) MDMA MDA Other: _____

If yes, age of first use:	Method of Use: (injected, Inhaled, Ingested, Snorted)	Date/Age last used:	Amount used in last 30 days:	Amount used in the last 48 hours:

Continued on next page

Other: Steroids Glue Paint Nitrous Oxide (Laughing Gas) Amyl or Butyl Nitrate (Poppers, Rush) Clonodine Non-prescription sleep or diet pills Elavil Sinequan Excedrin NoDoz Dexatrim Caffedrine Quick-Pep Vivarin Other: _____

If yes, age of first use:	Method of Use: (injected, Inhaled, Ingested, Snorted)	Date/Age last used:	Amount used in last 30 days:	Amount used in the last 48 hours:

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
	_____ Mood Swings	_____ Use less than before
____ Seizures	_____ Impulsivity	_____ Use more than before
____ DTs	_____ Euphoria	_____Use despite negative consequences
____ Fatigue	_____ Relaxation	_____Associate with using friends
____ Fever	_____ Extreme Jealousy	_____ Plan activities around use
____ Hallucinations	_____ Paranoia	_____ Loss of interest in activities
____ Heart racing	_____ Vivid, unpleasant dreams	_____ Change in work/school performance
____ Overdose	_____ Feelings of Guilt/Shame	_____ Work/school lateness or absenteeism
____ Appetite Problems	_____ Suicidal Thoughts	_____ Job loss due to use
____ Nausea/Vomiting	_____ Homicidal Thoughts	_____ Frequent arguments
____ Diarrhea	_____ Other	_____ Separation/divorce due to use
____ Sleep Problems		_____ Financial problems
____ Sexual Problems		_____ Legal problems
____ Injuries		_____ Physically abusive to self
____ Accidents		_____ Physically abusive to others
____ Other Medical Problems		_____ Suicide attempt(s)
		_____ Homicide attempt(s)

49. If any of the previous 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 (i.e. mood swings that quickly go from low to high and back again, and occur over periods of a few days and sometimes even a few hours)?** _____ If yes, explain: _____
_____

53. **Do you experience mood changes without obvious cause?** _____ 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: _____
_____
_____
_____

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