Neuropsychology of Northern Michigan

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ADULT PSYCHOSOCIAL QUESTIONNAIRE

Please fill out every section of this form to the best of your ability. If a section does not pertain to you please write "N/A". Any unfinished forms will be returned to patient/patient guardian upon staff review. Thank you!

Name: ____ **DOB**: _____________ **Today's Date:** ______________

Emergency Contact Name______________________________________ **Relationship to** Patient_________________

Cell #:(___________)______________________________ **Home #**: (___________)______________________________

Statement of problem/reason for appointment (including any specific reasons for seeking help at this time):

____

____

____

A. FAMILY OF ORIGIN

1. **Briefly describe your biological parents, your relationship to them, and whether they are living or deceased:**

____

____

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 to question #8, 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 CURRENTLY (YES OR NO)**

____

____

____

____

19. What is your current living situation? ____

20. What are your current spiritual/religious beliefs? _______________________________________

21. Are you experiencing any financial problems? ☐ **No** ☐ **Yes, as follows** ______________________

____

22. Are you experiencing any legal problems? ☐ **No** ☐ **Yes, as follows** _________________________

____

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

____

____

24. Have you ever been abused, abandoned, neglected, or exploited in any way? ☐ **No** ☐ **Yes**

If yes, please explain: ____

____

25. Check all that have occurred at any time:

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

26. 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	☐ Sore Throat
☐ Heat/Cold Sensitivity	☐ Prostate	☐ Other _____________	

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

____

____

____

28. Are you currently taking any prescribed medications(s)? ☐ No ☐ Yes

If yes, please list them below:

Drug Name	Route (oral, injection, etc.)	Dose	Frequency

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

____

____

____

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

____

____

____

31. List any operation, medical procedures, or hospitalizations for medical problems:

____

____

____

32. Date of last physical examination: ____________________

33. Name of Primary Care Physician: ____

34. Are you currently under the care of a physician for any active medical problems at this time?

☐ No ☐ Yes, as follows: ____

____

Patient Name: ____ DOB: ____________________

C. SUBSTANCE USE ASSESSMENT

35. 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 you answer "No" to question #35, 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

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

____

____

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

____

____

38. 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

39. How often do you drink the amounts checked on question #38: ____________________________

40. 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

41. Do you now, or have you ever had a problem with alcohol or drugs? ☐ Yes ☐ No

If no, skip to question #51. If yes, complete the following chart (question #43).

42. Has anyone else ever said you have a problem with alcohol or drugs? ☐ Yes ☐ No

If no, skip to question #51. If yes, complete the following chart (question #43).

43. Substance Use History

If yes to #41 or #42, 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 □ 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:

Sedatives-Hypnotics-Tranquilizers:

□ Seconal □ Valium □ Xanax □ Librium
□ Barbiturates □ Miltown □ Dalmanc □ Halcion
□ Restoril □ Reds □ Yellos □ 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)
□ Cocaine □ 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:

(Continued on next page.)

Opioids:

- ☐ Heroin
- ☐ Opium
- ☐ Morphine
- ☐ Methadone
- ☐ Darvon
- ☐ Codeine
- ☐ Percodan
- ☐ Demerol
- ☐ Dilaudid
- ☐ Dolophine
- ☐ Tylox
- ☐ Cough Syrup w/ Codeine
- ☐ 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
- ☐ MDMA
- ☐ MDA
- ☐ PCP (Angel Dust, Flakes, Greens)
- ☐ 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:

Other:

- ☐ Steroids
- ☐ Glue
- ☐ Paint
- ☐ Clonodine
- ☐ Nitrous Oxide (Laughing Gas)
- ☐ Seizure
- ☐ Arthritis
- ☐ Heart Disease
- ☐ Non-prescription sleep or diet pills
- ☐ Elavil
- ☐ Sinequan
- ☐ Excedrin
- ☐ NoDoz
- ☐ Dextrim
- ☐ Caffedrine
- ☐ Quick-Pep Vivarin
- ☐ Amyl or Butyl Nitrate (Poppers, Rush)
- ☐ 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:

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

____

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

____

____

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

____

____

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

____

Patient Name: ____ **DOB:** _____________________

48. What are your preferred substances (specific drugs and/or alcohol)? Rank in order.

1_________________________________ 3___________________________________

2_________________________________ 4___________________________________

49. 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)

50. If any of the previous are checked off, describe:

____

____

____

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

____

D. MENTAL HEALTH ASSESSMENT:

51. The best part of your youth was: ____

____

____

52. The worst part of your youth was: ____

____

____

Patient Name: ______________________________________ **DOB:** ____________________

53. **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)?** ☐ **Yes** ☐ **No**

If yes, explain: ____

54. **Do you experience mood changes without obvious cause?** ☐ **Yes** ☐ **No**

If yes, explain: ____

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

____

____

56. **What do you consider your:**

STRENGTHS	***WEAKNESSES***
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

57. **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

58. **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

Patient Name: ____ **DOB:** ____________________

59. **Please list any friends or family members who you think will be supportive of your treatment.**

Name of person(s):

____

____

____

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

____

____

____

____

____ ____________________

Patient and/or Legal Guardian Name (Printed) ***Date***

____ ____________________

Patient and/or Legal Guardian Signature ***Date***

____

____ ____________________

Reviewing Clinician Signature ***Credentials*** ***Date***