



DELTA FAMILY CLINIC SOUTH P.C.

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. Brothers and Sisters (Note if step and half-sister and/or brothers)

Name	(Circle one)	Birth date	Age	Relationship
_____	(Step/Half/Full)	____/____/____	_____	(Brother/Sister)
_____	(Step/Half/Full)	____/____/____	_____	(Brother/Sister)
_____	(Step/Half/Full)	____/____/____	_____	(Brother/Sister)
_____	(Step/Half/Full)	____/____/____	_____	(Brother/Sister)
_____	(Step/Half/Full)	____/____/____	_____	(Brother/Sister)
_____	(Step/Half/Full)	____/____/____	_____	(Brother/Sister)

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? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Mental illness? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Problems with alcohol or other drug use? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Physical or sexual abuse? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Criminal behavior? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Homicidal or suicidal behavior? | <input type="checkbox"/> No | <input type="checkbox"/> 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):

- | | | |
|--|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Never Married | <input type="checkbox"/> Married | <input type="checkbox"/> Divorced |
| <input type="checkbox"/> Living with someone | <input type="checkbox"/> Separated | <input type="checkbox"/> Widowed |

Patient Name: _____ DOB: _____ 2

18. List all children (including stepchildren):

Name	(Circle one)	Birth date	Age	Child Lives in the home
_____	(Step/Biological)	____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	(Step/Biological)	____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	(Step/Biological)	____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	(Step/Biological)	____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	(Step/Biological)	____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	(Step/Biological)	____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> 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:

- | | | | |
|--|---|--|--|
| <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"/> Thyroid Problems | <input type="checkbox"/> Pregnancy |
| <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"/> Encephalitis | <input type="checkbox"/> Blows to the head | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Prolonged fevers | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Gynecological problems | | | |

26. 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"/> Sore Throat |
| <input type="checkbox"/> Heat/Cold Sensitivity | <input type="checkbox"/> Prostate | <input type="checkbox"/> 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 Dalmane Halcion
 Restoril Reds Yellos Klonopin
 Phenergan Phenobarbital Tuinal Nembutal
 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
- Darvon
- Dilaudid
- Tylenol #3 or #4
- Opium
- Codeine
- Dolophine
- Pantapone
- Morphine
- Percodan
- Tylox
- Other: _____
- Methadone
- Demerol
- Cough Syrup w/ Codeine

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)
- STP
- MDA
- Other _____
- Mescaline
- Mushrooms
- PCP (Angel Dust, Flakes, Greens)
- Peyote
- Ecstasy
- Psilocybin
- MDMA

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

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 over 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? _____

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
<input type="checkbox"/> Blackouts	<input type="checkbox"/> Depression	<input type="checkbox"/> A.M. Use
<input type="checkbox"/> Memory Problems	<input type="checkbox"/> Confusion	<input type="checkbox"/> Sneaking
<input type="checkbox"/> Tremors/Shakes	<input type="checkbox"/> Concentration Problems	<input type="checkbox"/> Gulping
<input type="checkbox"/> Muscle aches	<input type="checkbox"/> Anxiety of Nervousness	<input type="checkbox"/> Loss of control
<input type="checkbox"/> Runny eyes/nose	<input type="checkbox"/> Irritability/Restlessness	<input type="checkbox"/> Relief use
<input type="checkbox"/> Large pupils, hair standing on end, or sweating	<input type="checkbox"/> Hostile/Aggressiveness	<input type="checkbox"/> Impulsive use
<input type="checkbox"/> Seizures	<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Use less than before
<input type="checkbox"/> DTs	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Use more than before
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Euphoria	<input type="checkbox"/> Use despite negative consequences
<input type="checkbox"/> Fever	<input type="checkbox"/> Relaxation	<input type="checkbox"/> Associate with using friends
<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Extreme Jealousy	<input type="checkbox"/> Plan activities around use
<input type="checkbox"/> Heart racing	<input type="checkbox"/> Paranoia	<input type="checkbox"/> Loss of interest in activities
<input type="checkbox"/> Overdose	<input type="checkbox"/> Vivid, unpleasant dreams	<input type="checkbox"/> Change in work/school performance
<input type="checkbox"/> Appetite Problems	<input type="checkbox"/> Feelings of Guilt/Shame	<input type="checkbox"/> Work/school lateness or absenteeism
<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Suicidal Thoughts	<input type="checkbox"/> Job loss due to use
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Homicidal Thoughts	<input type="checkbox"/> Frequent arguments
<input type="checkbox"/> Sleep Problems	<input type="checkbox"/> Other	<input type="checkbox"/> Separation/divorce due to use
<input type="checkbox"/> Sexual Problems		<input type="checkbox"/> Financial problems
<input type="checkbox"/> Injuries		<input type="checkbox"/> Legal problems
<input type="checkbox"/> Accidents		<input type="checkbox"/> Physically abusive to self
<input type="checkbox"/> Other Medical Problems		<input type="checkbox"/> Physically abusive to others
		<input type="checkbox"/> Suicide attempt(s)
		<input type="checkbox"/> 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: _____ 8

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 |

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

Patient Name: _____

DOB: _____