Susan Weltner-Brunton, Ph.D. & Associates, Inc.
921 Chatham Lane, Suite 112
Columbus, Ohio 43221
Phone 614-754-7648
Fax 614-754-7965

An Association of Independent Practitioners

Susan Weltner-Brunton, Ph.D.
Laura L. Williams, Ph.D.
Sabrina Chow, Ph.D.
Kerry A. Monahan, Psy.D.

Alissa Shrader, MSW, LISW-S
Avalon Espinoza, MSW, LISW-S
Nadiya Timperman, MS, MPH, RD, LD

Adult History Questionnaire

Name: _____

Gender: _____ DOB: _____ Age: _____

Ethic/Cultural issues we should be aware of:_____

_____

Family Information

Please complete this table to include the significant people in your life (e.g. brothers, sisters, grandparents, half-relatives, step-relatives) and specify relationship

			Living		Living with you	
Relationship	**Name**	**Age**	**Yes**	**No**	**Yes**	**No**
Parent						
Parent						
Spouse/Partner						
Children						

Developmental History

Please circle Yes or No and provide significant details

1. As far as you know, were there any problems with your mother's pregnancy with you? If yes, please give details: Yes No

2. Were there any problems associated with her delivery of you? Yes No
   If yes, please give details:

3. Did your mother use alcohol or other drugs during the pregnancy? Yes No
   If yes, please give details:

4. Did your mother smoke cigarettes during the pregnancy? Yes No
   If yes, please give details:

5. Did you have any significant delays in your development? Yes No
   (i.e. in walking, talking, sitting up, language) If yes, please give details:

6. Did you have any serious childhood illnesses/diseases/major surgeries? Yes No
   If yes, please give details:

7. Did you have any problems getting along with other children when Yes No

you were a child? If yes, please give details:

8. Please place a checkmark beside any of the following that you believe you had significant difficulties with as a child:

☐ Defiant	☐ Sleeping	☐ Anxious
☐ Hyperactive	☐ Inattentive	☐ Fighting
☐ Impulsive	☐ Depressed	☐ Motor Skills
☐ Withdrawn	☐ Stealing	☐ Aggressive
☐ Lying	☐ Memory	☐ Shy
☐ Language	☐ Toilet Training	☐ Fearful
☐ Eating	☐ Destructive	☐ Learning
☐ Stubborn	☐ Distractible	

☐ Strange Ideas (explain):

☐ Strange Behavior (explain):

Educational History

Fill in all that apply

Years of education: _____ Currently enrolled in school? Yes No

High School grad/GED? Yes No

Vocational: Yes No Number of years: _____ Graduated? Yes No Major: _____

College: Yes No Number of years: _____ Graduated? Yes No Major: _____

Graduate: Yes No Number of years: _____ Graduated? Yes No Major: _____

Other Training:

Special circumastances (e.g. learning disabilities, gifted):

Employment History

1. What is your current employment status? (circle one):

Full Time	Unemployed	Homemaker
Part Time	Student	Disabled

2. What is your current occupation? _____
3. Who is your current employer? _____
4. How long have your worked in your present job? _____
5. Please give us your history of employment since completing your education:

Job Title	**Time on Job (years)**	**Reason for leaving**

6. What is your longest period of employment at one place? _____
7. Have you ever been fired from a job? Yes No

   If yes, how many? _____

   Briefly describe the types of problems you have experienced with work, either at your current job or in the past:

Spiritual/Religious History

1. How important to you are spiritual matters? ____ Not ____ Little ___Moderate ___Much
2. Are you affiliated with a spiritual or religious group? Yes No
   If yes, please give details:

3. Were you raised within a spiritual or religious group? Yes No
   If yes, please give details:

4. Would you like your spiritual/religious beliefs incorporated into the counseling? Yes No
   If yes, please give details:

Military History

1. Military experience? Yes No
2. Combat experience? Yes No

Where:_____

Branch:_____ Discharge date: _____

Date drafted:_____ Type of discharge:_____

Date enlisted:_____ Rank at discharge:_____

Leisure/Recreational Activities

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity(check if exercise)	**How often now?**	**How often in the past?**
□		

□ _____

□ _____

□ _____

□ _____

□ _____

□ _____

□ _____

Social History

1. How would you describe your mood most of the time? (Circle one)

Cheerful/happy	Sad/depressed	Changes all the time
Anxious/nervous	Angry/irritable	Bland/unfeeling

2. Do your moods change *very* frequently, abruptly, and/or unpredictably? Yes No
   If yes, please give details: _____
   _____
3. Do you have trouble making friends? Yes No
4. Do you have trouble keeping friends? Yes No
5. Do you have trouble in your relationships with others? Yes No
   If yes, please give details: _____
   _____
6. Do you have problems with your temper? Yes No
   If yes, please give details: _____
   _____
7. Do you have a driver's license? Yes No
8. Has your license ever been suspended? Yes No
   If so, please explain why: _____
   _____
9. How many speeding tickets have you ever gotten? _____

10. Have you ever been stopped for driving while intoxicated? Yes No

11. How many car accidents, regardless of fault, have you ever been involved in? _____
12. How many times did your family move during your childhood and adolescent years? _____
13. How many times have you moved since leaving high school?_____
14. If you believe that you have Attention-Deficit/Hyperactivity Disorder, or ADHD, in what ways have your ADHD symptoms interfered with your life? _____

_____

_____

_____

15. In what ways have you tried to compensate for or cope with your deficits? _____

_____

_____

_____

Health History

Have you ever had any of the following:

Type of problem:	During Childhood	Past as an adult	Currently
Allergies/asthma			
Heart problems			
Epilepsy or seizures			
High blood pressure			
Serious head injury			
Injury resulting in loss of consciousness			
Lead poisoning			

Broken bones			
Surgery			
Migraine headaches			
Thyroid condition			
Problems with vision			
Problems with hearing			
Diabetes			

Any other serious medical problems (explain): Yes No

_____

_____

Are you currently taking any medications? Yes No

If yes, please give details:_____

_____

Please describe any other health difficulties you have experienced now or in the past:_____

_____

Family history of medical problems: _____

_____

_____

Please check if there have been any recent changes in the following:

___Sleep patterns ___Eating patterns ___Behavior ___Energy level

___Physical activity level ___General disposition ___Weight ___Nervousness/tension

Describe changes in areas in which you checked above: _____

_____

_____

Are you left-handed_____ right-handed_____ ambidextrous_____

Anyone in your family left-handed or ambidextrous? _____

If so, who?_____

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol								
Barbiturates								
Valium/Librium								
Cocaine/Crack								
Heroin/Opiates								
Marijuana								
PCP/LSD/Mescaline								
Inhalants								
Caffeine								
Nicotine								
Over the counter								
Prescription drugs								
Other drugs								

Substance of preference

1._____ 3._____

2._____ 4. _____

Family Mental Health History

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Check ay that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

	YES	NO	Family Member(s)
Depression	___	___	_____
Panic Attacks	___	___	_____
Schizophrenia	___	___	_____
Bipolar	___	___	_____
Suicide attempts	___	___	_____
Anxiety disorders	___	___	_____
Trauma history	___	___	_____
Learning disabilities	___	___	_____
Eating disorders	___	___	_____

Please use the following space to include any information you would like to share: