

ADULT HISTORY AND GOALS QUESTIONNAIRE

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PATIENT LABEL

Please complete this questionnaire and give it to your physician or therapist at your first appointment. This information will help your clinician gain an understanding of the problems for which you are seeking help and other important events in your life.

YOUR NAME IN FULL		DATE OF BIRTH	AGE
WHO REFERRED YOU TO LAUREATE		TODAY'S DATE	

WHAT EMOTIONAL, BEHAVIORAL OR INTERPERSONAL PROBLEMS ARE YOU EXPERIENCING

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HOW LONG HAVE THESE PROBLEMS BEEN AFFECTING YOUR LIFE

IF APPLICABLE, DESCRIBE HOW THE PROBLEMS ARE INTERFERING WITH WORK OR SCHOOL PERFORMANCE, FAMILY LIFE, SOCIAL LIFE, RELATIONSHIPS, YOUR ABILITY TO CARRY OUT ACTIVITIES OF DAILY LIVING LIKE CHORES AND BATHING

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DESCRIBE ANY STRESSFUL CIRCUMSTANCES YOU ARE EXPERIENCING THAT MAY BE CONTRIBUTING TO THESE PROBLEMS

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WHAT HAVE YOU DONE TO TRY TO SOLVE THE PROBLEMS

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HAVE ANY OF THESE SOLUTIONS BEEN HELPFUL

Yes No

PREVIOUS TREATMENT

Have you received previous treatment for mental health problems? No Yes (describe below)

DATE	NAME OF FACILITY OR PROFESSIONALS WHO PROVIDED TREATMENT	TYPES OF TREATMENT (Medication, Psychotherapy, Hospitalization, etc.)	RESPONSE

WHAT DID YOU FIND MOST HELPFUL ABOUT YOUR PREVIOUS TREATMENT

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Have you ever attempted suicide? Yes No

Do you consider yourself a high risk to attempt suicide in the near future? Yes No

Have you considered yourself or any family member a serious threat to do harm or be harmed by someone? Yes No

IF YES, DESCRIBE

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YOUR NAME IN FULL

DATE OF BIRTH

AGE

DEVELOPMENTAL HISTORY

DESCRIBE, IF KNOWN, ANY DIFFICULTIES YOUR MOTHER MAY HAVE HAD DURING HER PREGNANCY, LABOR OR DELIVERY WITH YOU

Indicate Any Problems Experienced During Childhood / Adolescence	Yes	No	Un-known	As a child or adolescent, did you experience any of the following?	
					DESCRIBE
Delayed speech				Physical abuse
Delayed motor development				<input type="checkbox"/> No <input type="checkbox"/> Yes
Excessive shyness				Sexual abuse	DESCRIBE
Excessive aggression				<input type="checkbox"/> No <input type="checkbox"/> Yes
Hyperactivity				Loss of a parent	DESCRIBE
Learning problems				<input type="checkbox"/> No <input type="checkbox"/> Yes
Poor peer relationships				Other trauma	DESCRIBE
Drug abuse				<input type="checkbox"/> No <input type="checkbox"/> Yes
Excessive alcohol consumption				DO YOU THINK THESE PAST EXPERIENCES OF LOSS AND TRAUMA ARE INFLUENCING THE PROBLEMS THAT BRING YOU TO TREATMENT? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Depression					
School failure / dropout					
Runaway behavior					
Illegal behavior					

FAMILY HISTORY

WHAT WAS IT LIKE TO GROW UP IN YOUR FAMILY? DESCRIBE ANY SIGNIFICANT EVENTS THAT YOU THINK MIGHT BE IMPORTANT IN UNDERSTANDING OR SOLVING THE PROBLEMS THAT YOU BRING TO TREATMENT.

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List any family members that have been treated for mental disorders such as schizophrenia, depression, manic depression, alcohol / drug addiction, attention deficit disorder or severe anxiety disorder and indicate the types of treatment they received (for example: psychotherapy, medication, hospitalization).

FAMILY MEMBER	DISORDER	TYPE OF TREATMENT

RELATIONSHIPS

DESCRIBE YOUR CURRENT FAMILY SITUATION

MARITAL STATUS

WHO LIVES IN YOUR HOME

IF APPLICABLE, WHAT ARE THE NAMES OF YOUR CHILDREN

WHO HAS LEGAL CUSTODY

WHAT ARE YOUR CHILD CARE ARRANGEMENTS

HOW MANY CLOSE FRIENDS DO YOU HAVE	DESCRIBE PROBLEMS, IF ANY, YOU THINK YOU HAVE IN DEVELOPING AND KEEPING FRIENDSHIPS

ARE YOU SATISFIED WITH THIS NUMBER	DESCRIBE PROBLEMS, IF ANY, YOU THINK YOU HAVE IN DEVELOPING AND KEEPING INTIMATE RELATIONSHIPS
<input type="checkbox"/> Yes <input type="checkbox"/> No
HAS THERE BEEN ANY VIOLENCE IN YOUR CURRENT FAMILY / SIGNIFICANT RELATIONSHIP (INCLUDING PUSHING, SHOIVING, RESTRAINING, HITTING, THREATENING OR INTIMIDATING GESTURES)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
HAVE YOU EXPERIENCED VIOLENCE IN PAST RELATIONSHIPS	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

YOUR NAME IN FULL

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AGE

EDUCATION AND EMPLOYMENT

LIST ANY RECENT CHANGES

DESCRIBE PLANS YOU HAVE TO MAKE CHANGES

EDUCATION

- Did not complete high school
- Completed high school
- Completed business/ Technical training
- Completed college
- Completed graduate training

OCCUPATION

- Homemaker
- Technical / Trade
- Sales
- Clerical
- Professional
- Unemployed
- Other

MILITARY SERVICE

BRANCH

HIGHEST RANK

TYPE OF DISCHARGE

- No
- Yes

MEANING AND SPIRITUALITY

WHAT GIVES YOUR LIFE MEANING

IS SPIRITUALITY OR RELIGION A SIGNIFICANT PART OF YOUR LIFE

- Yes
- No

DO YOU PARTICIPATE IN A SPIRITUAL COMMUNITY

- Yes
- No

WHAT RELIGION OR DENOMINATION DO YOU IDENTIFY WITH

HOW ACTIVE ARE YOU IN THIS COMMUNITY

WOULD YOU LIKE YOUR SPIRITUAL COMMUNITY TO BE INVOLVED IN YOUR TREATMENT

- Yes
- No

HOW CAN YOUR BELIEFS, VALUES, OR PRACTICES HELP YOU OVERCOME THE PROBLEMS THAT BRING YOU TO TREATMENT

OTHER IMPORTANT INFORMATION

RACE

- African American
- Asian
- Caucasian
- Hispanic
- Native American
- Other:

IF APPLICABLE, DESCRIBE ANY FINANCIAL DIFFICULTIES YOU ARE HAVING

IF APPLICABLE, DESCRIBE ANY PAST OR CURRENT LEGAL PROBLEMS

LIST WHAT YOU DO FOR FUN OR RECREATION (HOBBIES, PARTICIPATE IN SOCIAL ACTIVITIES SUCH AS CLUBS, SPECIAL INTEREST GROUPS, ETC.)

WHAT ARE YOUR STRENGTHS? LIST SKILLS AND TALENTS THAT IT TAKES TO BE GOOD AT THE ACTIVITIES, HOBBIES AND OTHER AREAS OF YOUR LIFE YOU JUST LISTED (FOR EXAMPLE: PATIENCE, QUICK THINKING, PERSISTENCE, ATTENTION TO DETAIL, ETC.)

WHAT AREAS OF YOUR LIFE ARE MOST SATISFYING TO YOU (E.G. CAREER, PARENTING, FRIENDSHIPS)

GOALS AND EXPECTATIONS

WHAT TYPE OF TREATMENT DO YOU HOPE TO RECEIVE FROM LAUREATE

- Assessment and consultation
- Medication
- Individual psychotherapy
- Specify other:
- Group therapy with people who have similar problems
- Marital or family therapy

DESCRIBE YOUR GOALS FOR TREATMENT

DURING THE COMING WEEKS, WHAT SUPPORT SYSTEMS (FRIENDS, RELATIVES, NEIGHBORS, CHURCH ORGANIZATIONS, ETC.) WILL BE AVAILABLE TO HELP YOU DEAL WITH THESE PROBLEMS

REVIEWED BY (CLINICIAN'S SIGNATURE)

CREDENTIALS

DATE