HURLEY MENTAL HEALTH ASSOCIATES
ADULT QUESTIONNAIRE

If you need help reading or writing, take this form to the front desk and they will arrange for someone to help you. It is very important that your therapist understand your needs. We are aware that this is sensitive information and assure you that all information is confidential. Please answer the questions as honestly as you can. If a question doesn't apply, write "NA". If you don't know an answer, write "unknown". Your therapist will review this questionaire with you.

*Name:*_____ *Age:*_____ *Sex:*_____

COMMENTS
(Therapist only)

What problems do you need help with today? _____

What changes do you hope for as a result of treatment? _____

What are your strengths? _____

What might get in the way of you meeting your goals? _____

Have you ever been involved in therapy before? Yes No
*If so please tell us when and where.*_____

RELATIONSHIPS

Name	*Age*	*Living*	*Date Deceased*
Father	____	*Yes/ No*	_____
Mother	____	*Yes/No*	_____
Step Father	____	*Yes/No*	_____
Step Mother	____	*Yes/No*	_____

Are (or were) your parents: Married Separated Divorced Never Married
What is/was communication like with your parents? Excellent Good Fair Poor
Please list brothers, sisters, stepbrothers, and stepsisters:

Name	*Age*	*Relationship*

What were your family relationships like? Cooperative Argumentative Distant Close

Have you ever witnessed or experienced abuse? (emotional, physical, or sexual)? Yes No

*If yes please explain:*_____

What limitations do you see in your family? _____

Can you share personal problems with anyone in your family of origin? Yes No
If yes, with whom? _____
Are members of your current family supportive of you getting treatment? Yes No
If yes, whom? _____

Has anyone in your family experienced the following? (Please check)

____*Emotional Problems*	____*Depression*
____*Anxiety*	____*Anger Problems*
____*Suicide Attempts*	____*Gambling Problems*
____*Relationship Problems*	____*Abuse Problems*
____*Alcohol/Drug Problems*	

COMMENTS
(Therapist only)

Did anyone in your family receive treatment for any of the above problems? Yes No
If yes, where and when? _____

Who are you living with now? _____

List marriages and or significant relationships you have had.

Name	*Married*	*Living Together*	*Boy/Girlfriend*	*How Long*
_____	*Yes/No*	*Yes/No*	*Yes/No*	_____
_____	*Yes/No*	*Yes/No*	*Yes/No*	_____
_____	*Yes/No*	*Yes/No*	*Yes/No*	_____

Please list your children and indicate if they are your natural, adopted, or step child.

Name	*Age*	*Natural*	*Adopted*	*Step*
_____	____	*Yes/No*	*Yes/No*	*Yes/No*
_____	____	*Yes/No*	*Yes/No*	*Yes/No*
_____	____	*Yes/No*	*Yes/No*	*Yes/No*

Are your children experiencing any emotional or alcohol or drug problems? Yes No
If yes, what are they, and are they getting help? _____
_____

Have you lost anyone close to you through death or separation? Yes No
If yes, please describe what happened and the effect this is having on you now.
_____
_____

Whom in your family do you feel closest to? _____

RECREATION *(please check)*

____*Sports*	____*Clubs/Groups*
____*Hunt Fish Camp*	____*Exercise Regularly*
____*Watch TV*	____*Electronic Games*
____*Internet/Computer*	____*Read*

Are you frequently bored? Yes No
Please explain: _____
_____
Has your use of free time recently changed? Yes No
Please explain: _____
_____
Are drugs/alcohol often involved in your recreational or hobby activities? Yes No

SEXUALITY *(do you consider yourself)*

COMMENTS *(Therapist only)*

Heterosexual (opposite sex) Gay/Lesbian (same sex) Bi-sexual (both sexes) Unsure
*At what age was your first sexual experience:*_____
Is there any area of your sexuality with which you are not comfortable? Yes No
*Please describe:*_____
_____
Have you ever considered that some experiences meant you were sexually abused? Yes No
Please check all that apply:

_____*Sexually active now*
_____*Sexually active in the past*
_____*Use birth control*
_____*Concerned about sexually transmitted disease*
_____*Have had unprotected sex*
_____*Have unanswered questions about sex.*
_____*Experienced sexually transmitted disease*

*Please describe any other sexual concerns:*_____

LEGAL

Have you had any arrests, convictions, misdemeanors, felonies, and parole/probation? violations or incarcerations as either a youth or an adult? Yes No
*If yes, please explain:*_____
_____
What is your current legal status?

_____*No problems* _____*Problems* _____*On tether*
_____*License suspended* _____*License revoked* _____*Awaiting trial*
_____*On probation/parole*

*Name and phone number of Parole/Probation Officer*_____

VOCATIONAL HISTORY

Are you currently in school? Yes No
*What was the last grade you completed in school?*_____
*Do you have any current educational goals?*_____
Did you participate in extracurricular activities such as sports or choir? Yes No
*Please list:*_____
Did you get along with your teachers and classmates? Yes No
Do you feel you have a learning problem? Yes No
Did you ever repeat a grade? Yes No
What were your grades like? Above Average Average Below Average
What was your attendance like? Never absent Occasionally Absent Frequently Absent
*Please describe additional training you've had:*_____
_____
Do you have a job now? Yes No Full-time Part-time

Jobs held in the last five years	*Time at each:*
_____	_____
_____	_____
_____	_____

What is you job attendance like? Above Average Average Below Average

*What do you like most about your job?*_____

*What do you like least?*_____

Is there another occupation you would prefer? Yes No
If so, what? _____

COMMENTS
(Therapist only)

Are your co-workers supportive of your getting help? Yes No

*If you are not working, but would like to be, what are your plans to get a job?*_____
_____

*Describe any current job or school problems:*_____
_____

Are you experiencing any financial problems? Yes No

Have you had military service experience? Yes No
Have you completed combat duty? Yes No
*Branch of service:*_____*Years of Service*_____
*Reason for separation?*_____

PEER RELATIONSHIPS *(which best describes your relationships)*

_____*Don't have any*
_____*Legal problems*
_____*Gambling centered*
_____*Athletic*
_____*Alcohol/drug-centered*
_____*Caring*
_____*Spiritual*
_____*Unpopular*
_____*Supportive*
_____*Emotional problems*
_____*Temper problems*
_____*Followers*
_____*Angry with me*
_____*Problematic*
_____*Popular*

*Other information about friends that you think is important?*_____
_____
Please list first names of a few of the friends who are most important to you:

Name	*Length of time known*
_____	_____
_____	_____
_____	_____

Do you talk about problems with your friends? Yes No
*Who do you trust most in your life right now?*_____
*Who in your life might be available to support you in treatment?*_____

DEVELOPMENTAL
As a youth did you experience any of the following?

Problem	*Age*	*Problem*	*Age*
_____*Serious accidents*	_____	_____*Hospitalizations*	_____
_____*Trouble with police*	_____	_____*Shyness*	_____
_____*Head injury*	_____	_____*Suicidal thoughts*	_____
_____*Running away*	_____	_____*Witnessed abuse*	_____
_____*Growth concerns*	_____	_____*Violence problems*	_____
_____*Behavior problems*	_____	_____*Pregnancy(s)*	_____
_____*Abortion(s)*	_____	_____*Sleeping problems*	_____
_____*Fear Problems*	_____	_____*Hearing problems*	_____
_____*Stuttering*	_____	_____*Emotional abuse*	_____
_____*Eating problem*	_____	_____*Speech problems*	_____
_____*Sexual abuse*	_____	_____*Suicide attempts*	_____
_____*Physical abuse*	_____	_____*Visual problems*	_____
_____*Depression*	_____	_____*Gang involvement*	_____
_____*Self esteem problems*	_____	_____*Gambling problems*	_____
_____*Cult/Satanic experience*	_____		

Are you aware of any major difficulties at the time of your birth or early infancy?
Yes No

COMMENTS
(Therapist only)

As a youth did you belong to any formal or informal groups? Yes No

*Describe:*_____
_____
Who or what has been most influential in your life? _____
_____

SPIRITUAL

_____*I believe in God/Higher power* _____*I don't believe in God/Higher power*
_____*I attend church/temple/mosque* _____*I don't attend church/temple/mosque*

*What values and/or spiritual beliefs are important to you?*_____
_____

MORE ABOUT YOU

*How do you feel most of the time?*_____

*When I feel mad I....*_____

*When I feel sad I....*_____

*When I feel glad I..*_____

*When I feel afraid I...*_____

*How have you been affected positively or negatively by your race, nationality, cultural? background?*_____
_____
_____

Have you ever attended self-help or support groups? Yes No
*Please explain:*_____
_____
_____
_____

*Is there anything else you would like your therapist to know about you?*_____
_____
_____

Thank you*.....*

_____ _____
Client's Signature *Date*

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HURLEY MENTAL HEALTH ASSOCIATES
HEALTH QUESTIONAIRE

*PATIENT NAME (Print Only)*_____

Height: _____ *Weight:* _____

1. *Do you have any medical symptoms at the time of this interview or persistent chronic or acute symptoms, which have lasted for more than a week such as pain, physical complaints, etc?*
   *Yes*_____ *No*_____ *Specify*_____
2. *Please indicate any physical disabilities, limitations, or ailments for which you have been treated:*
   _____
   _____
3. *Do you have a history of intravenous drug use, unconsciousness, hepatitis, or DT'S?*
   Yes _____*No* _____ *Specify*_____
4. *Do you have communicable disease (including any sexually transmitted diseases)?*
   *Yes*_____ *No*_____ *Specify*_____
5. *When were you last treated by a physician?* _____
   For what? _____
6. *When and where was your last physical?* _____
7. *Have you ever had surgery Yes* ____ *No* _____ *For what?* _____
   _____
   _____
8. *Do you smoke cigarettes? Yes*_____ *No*_____
   If yes, how many per day or per week? _____
9. *Do you drink alcoholic beverages? Yes*_____ *No*_____
   If yes, how much and how often? _____
10. *Do you drink caffeinated beverages (coffee, tea, colas, Mt. Dew, etc..)?*
    *Yes*_____ *No*_____ *If yes, how much per day?* _____
10. *Have you ever been in treatment at a detox or residential substance abuse or psychiatric program?*
    *Yes*_____ *No*_____ *Date Last Attended:*_____

*COMMENTS*_____
_____

*Have you ever been in counseling or therapy before? Yes*_____ *No*_____,
If so please explain:

_____
_____
_____
_____

(over)

Briefly describe your reason for seeking help _____

_____

_____

Please give any additional information that may be of any help to us:

_____

_____

_____

_____

Please circle any of the following problems, which pertain to you:

Nervousness	*Depression*	*Fears*
Shyness	*Sexual Problem*	*Suicidal Thoughts*
Separation	*Divorce*	*Finances*
Drug Abuse	*Alcohol Use*	*Unhappiness*
Anger	*Self Control*	*Friends*
Sleep	*Stress*	*Work*
Relaxation	*Headaches*	*Tiredness*
Legal Matters	*Memory*	*Ambition*
Energy	*Insomnia*	*Loneliness*
Decision Making	*Concentration*	*Thoughts*
Education	*Career Choices*	*Health Problems*
Temper	*Nightmares*	*Marriage*
Children	*Appetite*	*Stomach Trouble*
Bowel Trouble	*Pain*	

*CLIENT SIGNATURE*_____*DATE*_____

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HURLEY MENTAL HEALTH ASSOCIATES

MEDICATION LIST

Patient Name: _____

Date of Birth: _____

ALLERGIES: _____ **Date/Initials**_____ _____
Date/Initials_____

_____ **Date/Initials**_____ _____ **Date/Initials**_____

_____ **Date/Initials**_____ _____ **Date/Initials**_____

Drug Name (include dose, route, frequency)	Date Reviewed/ Initials	Date Reviewed/ Initials	Date Reviewed/ Initials	Date Reviewed/ Initials	Date Reviewed/ Initials

KEY:

Initials:_____ Name:_____ Clinic:_____ Initials:_____ Name:_____ Clinic:_____

Initials:_____ Name:_____ Clinic:_____ Initials:_____ Name:_____ Clinic:_____

Initials:_____ Name:_____ Clinic:_____ Initials:_____ Name:_____ Clinic:_____

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Patient Name:_____ Date:_____

Center for Epidemiologic Studies Depression Scale (CES-D)

Instructions: Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way **during the past week**.

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1. I was bothered by things that usually don't bother me.				
2. I did not feel like eating; my appetite was poor.				
3. I felt that I could not shake off the blues even with help from my family or friends.				
4. I felt I was just as good as other people.				
5. I had trouble keeping my mind on what I was doing.				
6. I felt depressed.				
7. I felt that everything I did was an effort.				
8. I felt hopeful about the future.				
9. I thought my life had been a failure.				
10. I felt fearful.				
11. My sleep was restless.				
12. I was happy.				
13. I talked less than usual.				
14. I felt lonely.				
15. People were unfriendly.				
16. I enjoyed life.				
17. I had crying spells.				
18. I felt sad.				
19. I felt that people disliked me.				
20. I could not get "going."				