THERAPEUTIC SERVICES AGENCY, INC.

220 Railroad St. SE • Pine City, MN 55063 • (320) 629-7600 • Fax (651) 925-0071

ADULT HISTORY QUESTIONNAIRE

Name: _____Age: _____ Gender:_____Today's Date:_____

Date of Birth: _____Race:_____

Address:_____ Phone:_____Is it okay to leave a message? ___Yes ____No

_____ Phone: _____Is it okay to leave a message? ___Yes ____No

Emergency Contact:_____ Phone:_____Relationship:_____

Current Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single (never married)

Are you employed? ❑ No ❑ Yes If yes, how many hours per week? _____ What do you do?
_____

Are you experiencing problems at work? ❑ No ❑ Yes If yes, describe

_____

_____

Do you attend school? ❑ No ❑ Yes What is the highest level of education you completed?_____

Do you have a history of military service? ❑ No ❑ Yes If yes, what branch and years of service?_____

Primary Household
(Who currently lives in your home?)

Name	Relationship to you	Age	Quality of relationship

Were you referred to TSA (if yes, who and for what reason)?_____

What led you to seek our services? _____

_____

_____

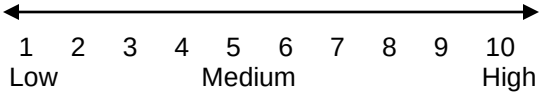
When did this problem begin? _____

How often does this problem occur?

O Daily O Some days
O Most days O Under certain circumstances

How severe is the problem now?

(on a scale 1 to 10; 1 is the lowest and 10 is highest)



Have you experienced any of the following (please check)?

- ☐ Previous mental health issues or evaluation
- ☐ Psychiatric hospitalization
- ☐ Suicide attempt(s)
- ☐ History of self-injurious behavior
- ☐ Prior mental health diagnosis
- ☐ Prior mental health treatment
- ☐ War
- ☐ Crime victim
- ☐ Unhappy childhood
- ☐ Out of home placement as a child
- ☐ Legal Issues
- ☐ Victim of abuse:
  - ☐ Physical
  - ☐ Sexual
  - ☐ Emotional
- ☐ Threats of violence towards others

Please describe any of the items endorsed above: _____

_____

Checklist of Current Concerns (Please check all that apply)

- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness, panic, phobias, fear
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Confusion
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Drug use—prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems—overeating, under-eating, appetite, vomiting
- ❑ Fatigue, tiredness, low energy
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Housework/chores—quality, schedules, sharing duties
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Legal matters, charges, suits
- ❑ Loneliness
- ❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ❑ Memory problems
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ❑ Pain, chronic
- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism
- ❑ Procrastination, work inhibitions, laziness
- ❑ Relationship problems (with friends, with relatives, or at work)
- ❑ Self-esteem
- ❑ Sexual issues
- ❑ Shyness, oversensitivity to criticism
- ❑ Sleep problems—too much, too little, insomnia, nightmares
- ❑ Smoking and tobacco use
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stress, relaxation, stress management, stress disorders, tension
- ❑ Suicidal thoughts
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems, employment, workaholic/ overworking, can't keep a job, dissatisfaction, ambition

Medical Health History

Please rate your current physical health: _____excellent _____good _____fair _____poor

Current primary care physician: _____

Date last seen by primary care physician: _____ **Do you have allergies? ❑ No ❑ Yes**

Please list all current prescription medications and dosages that you are taking and the purpose for each:

_____

_____

Please list all over-the-counter medications, vitamins, or supplements you are currently taking:_____

_____

Please list all current medical conditions:_____

_____

Please list all significant diseases, illnesses, accidents, injuries, head trauma, surgeries, and hospitalizations:

_____

_____

_____

Substance Use (Please check all that apply)

Substance	Past Use	Current Use
Alcohol		
Tobacco		
Caffeine		
Marijuana		
Methamphetamine		
Narcotics		
Cocaine		
Heroin		
Prescription Drugs		
Other:		

CAGE-AID

1. Have you ever felt you ought to cut down on your drinking or drug use? ____Yes _____ No
2. Have people annoyed you by criticizing your drinking or drug use? ____Yes _____ No
3. Have you felt bad or guilty about your drinking or drug use? ____Yes _____ No
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? ____Yes _____ No

Do you use tobacco? ❑ No ❑ Yes If yes, how many cigarettes/cigars/other do you use each day? _____
If yes, are you interested in smoking cessation? ❑ No ❑ Yes

How much coffee, cola, tea, or other sources of caffeine do you consume each day? _____

Legal issues as a result of drug and/or alcohol use: _____ No ___ Yes Describe: _____

_____

Do you have a history of participating in a chemical dependency treatment program? ____ No _____ Yes

If yes, please describe when and where you were in treatment:_____

Legal History

Do you have a history of legal charges? _____No _____Yes

If yes, please describe charges:_____

_____

Are you currently on probation? _____No _____Yes Have you ever been on probation? _____No _____Yes

Family History (please check if the following pertain to any of your family members)

- ☐ Mental health issues
- ☐ Significant family disruption
- ☐ Alcohol abuse
- ☐ Substance Use
- ☐ Legal Issues
- ☐ Physical health concerns/disabilities
- ☐ Cognitive or learning disabilities
- ☐ Financial stressors
- ☐ Abuse Issues:
  - ☐ Victim
  - ☐ Perpetrator

Please describe any of the items endorsed above: _____

_____

_____

Please complete the following:

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself — or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that others have noticed. Or the opposite -- being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or of hurting yourself in some way				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very difficult** **Extremely difficult**

Generalized Anxiety (GAD-7)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Feeling nervous, anxious or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it is hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

Please identify some of your strengths and interests: _____

_____

_____

_____

Please provide any additional information you would like to share: _____

_____

_____

_____