

TRI-COUNTY CHRISTIAN COUNSELING SERVICES, INC.
8195 Beckett Road
West Chester, Ohio 45069
(Located in the facilities of Tri-County Baptist Church)
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www.tcccs.com

ADULT HISTORY QUESTIONNAIRE

Client Name: _____ Date: _____
Phone # (H) _____ (W) _____ (C) _____
Date of Birth: _____ Social Security Number: _____

Purpose of this form:

The purpose of this questionnaire is to obtain a comprehensive picture of your background along with current strengths and difficulties. Completing these questions as fully and accurately as you can will be of help to you and to your therapist in providing services to you. You may answer these routine questions on your own time rather than taking up your therapy session time. This information is considered confidential and will be treated as outlined in the “**TCCCS Introduction to Our Counseling Relationship**” form. If you do not want to answer any of the items, write: “Do not want to answer”.

REFERRAL DATA

How did you find out about TCCCS? _____
By Whom were you referred? _____
May we inform him/her that you have initiated therapy? YES NO (Please circle one)

PROBLEM DESCRIPTION

In your own words, what the difficulties you are currently experiencing? _____

When did these difficulties first begin? _____
Was there some specific incident or event which seemed to cause these difficulties to begin? YES NO (Circle one) If so, What? _____
What have you done on your own to attempt to resolve these concerns? _____

How have these solutions worked? _____
Have you contacted other professionals for help with these concerns? YES NO (circle one)
If so, whom? _____
When? _____ For how long? _____

CURRENT FAMILY/SIGNIFICANT OTHERS

Marital Status: Single Engaged Married Separated Divorced Widowed
Co-habiting (Circle all that apply)

List those living with you, their ages and relationship to you:

How many times have you been married? ____ Dates of these marriages _____

How did these marriages end, and when? _____

Do you have children not living with you? ____ If so, list them, why they live elsewhere, and the quality of your relationship with them now: _____

Briefly describe the positive qualities of your current/romantic relationship: _____

Briefly describe the negative aspects of the relationship: _____

Is the quality of your sexual relationship(s) an issue you wish to address in therapy?

YES NO

Is the quality of your relationships with children or parenting issues something you wish to address in therapy? YES NO

Are there other important aspects of your current significant relationships that you would like to add? YES NO If so, please indicate: _____

FAMILY HISTORY

By whom were you raised? (If several sets of circumstances, list all, and ages for each)

Where did you grow up? _____ Urban Rural Small Town? (Circle one)

Parents' education (Highest grade completed: M _____ F _____

Parents' occupation (Pre-retirement): M _____ F _____

Parents' religious affiliation: _____

Your current religious affiliation: _____

To what extent do you want spiritual values/issues addressed in your therapy? _____

Do you want your sessions to end with Prayer? Yes No (Circle one)

Please list all brothers and sisters including the first names and their ages, from oldest to youngest, and including yourself in the appropriate position: _____

Did any of the following happen to you? If yes, indicate the age(s) at which they took place on the lines to the left of the event:

- | | | |
|----------------------------------|----------------------------------|--------------------------|
| ____ Death of Mother | ____ Death of Father | ____ Death of Sibling |
| ____ Separation of Parents | ____ Parental Divorce | ____ Physical Abuse |
| ____ Serious Illness (Self) | ____ Desertion by Mother | ____ Desertion by Father |
| ____ Parent(s) Alcoholic/addicts | ____ Sexual Abuse | ____ Adopted |
| ____ Mental illness in family | ____ Long-term illness in family | |

SOCIAL RELATIONSHIPS

How often do you socialize with others? _____
How many friends do you have whom you see socially at least once per month? _____
Do you have close friends with whom you can discuss your problems, interests, and concerns? YES NO (Circle one)
What hobbies or leisure activities do you pursue? _____
What clubs or organizations do you participate in? _____

MEDICAL/PHYSICAL FUNCTIONING

Height: _____ Weight: _____ Date of last physical examination: _____ **Were there any abnormal or irregular findings?** YES NO (Circle one) If so, please list: _____

Who is your family physician? _____ **Phone #** _____

Check any of the following you have had:
___ Breathing problems ___ High blood pressure ___ Neurological problems
___ Heart Condition ___ Epilepsy/Convulsion ___ Endocrine problems
___ Pregnancy/abortion ___ Stroke ___ Cancer ___ Dizziness/Fainting ___ Headaches
___ Diabetes ___ Other _____

List any surgeries you have had, and dates: _____

List any current medical problems: _____

List any medication you are currently taking:

Medication	Dosage	#times/day	Why Prescribed?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Note any adverse affects or side affects that you have to any medications: _____

List any allergies you have: _____

Check those you are currently experiencing:

___ Sleep Problems: (___ too much ___ too little ___ early awakening ___ frequent awakening
___ sleepwalking ___ hard to get to sleep)
___ Eating Problems: (___ too much ___ too little ___ eating when not hungry)

MENTAL HEALTH HISTORY

Have you ever been treated by a mental health professional or by your physician for emotional or mental health issues? YES NO (Circle one) (If no, skip this section)

Name of professional and/or facility, and dates of treatment: _____

May we request treatment records from them? YES NO (Circle one)

How were the issues resolved? _____

If you have been on medication for mental health reasons (other than those listed in the medical section above) at any time in the past, please list here:

Medication Used	Dosage	#times day	Why Prescribed	When
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

SUBSTANCE USE AND DEPENDENCY

How often do you currently use the following substances? (Place a check in the column to indicate current use. If your past use was different, indicate this by writing "past" in the appropriate column next to each substance.

How often do you currently use the following substances? (Place a check in the column to indicate current use. If your past use was different, indicate this by writing "past" in the appropriate column next to each substance.

	1X	Daily	3-5X week	1-2X week	2-3X week	Seldom	Never
Beer	___	___	___	___	___	___	___
Wine	___	___	___	___	___	___	___
Distilled Alc.	___	___	___	___	___	___	___
Marijuana	___	___	___	___	___	___	___
Cocaine	___	___	___	___	___	___	___
Crack	___	___	___	___	___	___	___
Barbiturates	___	___	___	___	___	___	___
Amphetamines	___	___	___	___	___	___	___
Tranquilizers	___	___	___	___	___	___	___
Analgesics	___	___	___	___	___	___	___
Heroin	___	___	___	___	___	___	___
Tobacco	___	___	___	___	___	___	___
Caffeine	___	___	___	___	___	___	___

Have you ever had job, relationship, financial, legal, social, or physical problems as a result of your substance use? YES NO (Circle one) If so, describe:_____

Has anyone in your family ever had problems with substance abuse or dependency? YES NO

Please list:_____

Have you or others in your family been involved in treatment for substance use or dependency?

YES NO (Circle one) If so, describe:_____

Have you ever been involved with a 12-Step group(AA, Al-Anon, etc.)? YES NO (Circle one)

Are you now? YES NO (Circle one) If so, what groups?_____

BEHAVIORAL ADDICTIONS

Do you consider yourself to be addicted to activities or behaviors which are not chemical in nature (e.g. food, television, exercise, gambling, computer (games, internet) pornography, sex, etc.)?

YES NO (Circle one) If yes, please list:_____

Any prior treatment for these? YES NO (Circle one)

EDUCATIONAL/OCCUPATIONAL FUNCTIONING

Current Occupation/Vocation:_____

Length of time in current vocation:_____ Is your vocation fulfilling? YES NO (Circle one)

Are you considering changing jobs or vocations? YES NO (Circle one)

Have you had any disciplinary actions against you at work? YES NO (Circle one)

List your highest educational achievement (HS Diploma, BA/BS 2 years college etc.)_____

Your grades were: ___Above Average ___Average ___Below Average

Extra curricular activities you participated in:_____

If you left high school before graduation, note the reason_____

Did you get a GED?_____

LEGAL HISTORY

Have you ever been convicted of a felony? YES NO (Circle one) If yes, give details:_____

Are you currently on probation or parole? YES NO (Circle one) If yes, give details:_____

Have you been ordered to receive counseling as a result of your involvement with the legal system? YES NO (Circle one) If yes, give details:_____

Please list any other individuals or legal agencies with whom you need for us to confer(to meet the conditions of parole, etc)_____

If you wish for us to be in contact with your attorney, please list data here:

Attorney' name: _____

Address: _____

City, State, Zip: _____

Telephone number: _____

(Please note that Carol will not appear as a witness in Court. If she needs to consult with outside resources, there will be a charge at the rate of \$150.00 per hour which includes any report writing that is requested.)

If there is anything we need to know that has not yet been covered, please indicate below:
