DEBORAH CARNETT, M.ED, MS, LMHC
LICENSED MENTAL HEALTH COUNSELOR

ADULT QUESTIONNAIRE

Please Print:

Name: _____ Gender: _____Age: _____ DOB: _____

Address: _____ City: _____ Zip code: _____

Home Phone Number: _____ Cell Number: _____

Work Number: _____ Other: _____

Please check the best phone where I can contact you or leave a message: ____work ____ home ____ cell

What is your occupation? _____ Employer: _____

Are you a Student? Yes___ No_____ If 'Yes', where? _____

Emergency Contact Person: _____ _____
(Name of Contact Person) (Phone Number)

Relationship to you: _____

Children:
Name: _____ Age:_____ Living at home? Yes____ No_____
Name: _____ Age:_____ Living at home? Yes____ No_____
Name:_____ Age:_____ Living at home? Yes____ No_____
Name:_____ Age:_____ Living at home? Yes____ No_____

RELATIONSHIP INFORMATION

Your marital status: ____Married ____Divorced ____Single _____Widowed _____Domestic Partner

Year of 1st marriage _____ Year Divorced_____ # of children_____
Year of 2nd marriage _____ Year divorce _____ # of children _____

Are you currently living with a spouse or partner? _____ Yes _____ No

Spouse/Partner's First Name & Age: _____

Describe your relationship with your Spouse/Partner: (Place an "X" on the line below)

{_____{_____{_____}
Major problems Minor problems Satisfactory Very Satisfactory

Reasons for relationship problems: Check all that apply:

__ finances
___children
___parents or in-laws
___work situation
___physical, emotional abuse
___addiction
___other: _____

____religion
____pain problem
____sexual difficulties
____physical illness
____disability
____health problems

____communication problems
____child discipline
____legal problems
____personality differences
____infidelity
____different life goals

FAMILY HISTORY

Where were you born and raised? _____

Please list first names and ages of Brothers and Sisters:

First Name	Age	Relationship (natural, step, half)	Deceased? Y or N	Year?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please check all information which applies to your parents:

Mother's 1st Name _____ Father 's First Name: _____

____living - Current Age: _____
____deceased _____year
____married _____divorced _____# of times
____remarried

_____living – Current Age: _____
____deceased _____year
_____married _____divorced _____# of times
_____remarried

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents?
_____

Describe your relationship with your mother while growing up: _____

Current relationship with your mother? _____

Describe your relationship with your father while growing up: _____

Current relationship with your father: _____

HEALTH HISTORY Please list any health problems:
_____
_____

Please list current: Medications/Supplements	Dosage	Condition for which it was prescribed:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Doctor's Name & Phone Number: _____

Do you smoke? _____ If so, how much a day/week? _____
Do you use recreational drugs? _____If so, what kind and how often? _____
Do you use alcohol? _____ If so, how much a day/week? _____
Ever attended outpatient/inpatient chemical dependency treatment? _____ If so, when? _____
Any pending legal issues? _____
Sleep issues? _____ Please describe: _____
Appetite/weight issues? _____ Please describe: _____

Please describe the problem that has brought you to see me:

LEARNING NEEDS & SENSITIVITIES:

Please check those that apply to you:

_____ ADD or ADHD
_____ Autism
_____ Asperger's
_____ Sensitivity to light, sound, smells
_____ Had special education classes in school (IEP)
_____ Learning Disability
_____ Math difficulty
_____ Reading or writing problems
_____ Auditory processing problem
_____Other: _____

SPECIFIC CONCERNS:

Please check any that apply to you NOW. Put a "P" by any that occurred in the PAST:

_____Abuse (spouse/partner)
_____ Alcohol/Drug abuse
_____Anger
_____ Anxiety/Stress
_____Childhood abuse
_____Concentration problems
_____Compulsions
_____Cutting/Self-injury
_____Depression
_____Divorce/Separation
_____Eating problems
_____Fatigue/low energy
_____Fears/Phobias
_____Gambling problem
_____Gender identity concerns
____Grieving/Losses
____Headaches/Pains
____Health/Illness/Medical
____Internet problems
____Impulsiveness
____Legal matters
____Loneliness
____Marital conflict
____Memory problems
____Mood Swings
____Motivation/Laziness
____Tension/Nervousness
____Obsessions
____Oversensitive to rejection
____Panic/Anxiety Attacks
____Perfectionism
____Procrastination
____Relationship problems
____Low self-esteem
____Poor Self-care
____Sexual issues/conflicts
____Sleep problems
____Suicidal thoughts
____Smoking/Tobacco use
____Low frustration tolerance
____Weight & diet issues
____Withdrawal/isolating
____Work problems

How did you hear about my services? Psychology Today ____ Web ___ Referred by:_____

What are your goals for seeking treatment at this time? _____

_____

_____

_____ _____

Client Signature Today's Date