# Adult Personal Health Questionnaire

Zumbro Valley Mental Health Center

Date _____

Date of Assessment _____ Clinical ID # _____

**Personal History Questionnaire**

Thank you for completing this questionnaire. Your answers will help us get to know you and to understand your needs. If you have any questions, please ask the desk staff. If you need more room to answer a question, please use the back of each page

Name _____ Date of Birth _____

Age _____ Gender Male ☐ Female ☐

Please describe the issue(s) that brings you here:

_____

_____

_____

When and how did the problem start?

_____

_____

_____

Please check the symptoms you are having **now**:

| | | |
|---|---|---|
| ☐ Decreased appetite/weight loss | ☐ Sleep problems | ☐ Guilt feelings |
| ☐ Excessive worry | ☐ Poor concentration | ☐ Frequent mood swings |
| ☐ Hear voices | ☐ Distressing memories | ☐ Violent behavior |
| ☐ Sexual issues/concerns | ☐ Restless/fidgety | ☐ Aches/pains |
| ☐ Poor memory | ☐ Numbness/tingling | ☐ Lack of motivation |
| ☐ Dizziness | ☐ Feel inferior | ☐ Headaches |
| ☐ Nightmares | ☐ Loneliness | ☐ Low self-esteem |
| ☐ Social discomfort | ☐ Hopelessness | ☐ Tense feelings |
| ☐ Depressed/sad | ☐ Irritable/angry | ☐ Lose temper |
| ☐ Difficulty breathing | ☐ Shaking | ☐ Feel unworthy |
| ☐ Can't enjoy myself | ☐ Low energy/tired | ☐ Anxious/nervous |
| ☐ Cry easily/often | ☐ Heart racing | ☐ Body image concerns |
| ☐ Increased appetite/weight gain | ☐ Wound up | ☐ Repetitive actions |
| ☐ Heavy feeling | ☐ Ashamed | ☐ Choking feeling |
| ☐ Disturbing thoughts | ☐ Thoughts of wanting to die | ☐ Racing thoughts |
| ☐ Thoughts of wanting to hurt others | ☐ Self-harming behaviors/urges | ☐ See images or objects |
| ☐ Feeling paranoid/suspicious | ☐ Elevated mood | ☐ |

Other: _____

How has the problem/symptoms affected your life?

_____

_____

How has the problem/symptoms affected your life?

_____

_____

**MENTAL HEALTH HISTORY**

Please list previous mental health treatments or evaluations (date, reason, name of facility/therapist):

Please describe what you learned or found helpful from previous treatment:

Please tell us about any medications that were prescribed **in the past** for emotional or psychological problems, if they helped or if you had any side effects:

If any members of your family have experienced problems with mental illness, please tell us their relationship to you and the nature of their problem:

Please tell us about any suicide attempts or self-harming behaviors, past or current:

Are you currently thinking about hurting or killing yourself or someone else?

Please list any medications you are taking now for emotional or psychological problems, if they are helping and if you have any side effects:

**FAMILY HISTORY**

Where were you born?

Who raised you and where?

Are your parents currently married to one another (Yes or No)?

If no, how old were you when they divorced?

Who was in your family growing up?

What was it like growing up in your family?

Was there any violence or other abuse in your family growing up (please describe)?

What are your relationships with your parents and siblings like now?

**SOCIAL HISTORY**

If you are married now or have a domestic partner, please tell us their name:

Length of relationship:

Years married (if applicable):

Please describe the relationship:

Any previous marriages or committed relationships? Yes ☐ No ☐

If you have children, please tell us their name(s):

Any there any custody agreements? Yes ☐ No ☐

Who is living with you now?

Do you feel any of your relationships have been abusive (physical, financial, sexual, verbal, emotional)? Yes ☐ No ☐

If yes, please describe:

Are you happy with your current life?

What do you like to do in your spare time?

**EDUCATION/OCCUPATION HISTORY**

What is your highest level of education?

What was school like for you?

Approximately how many jobs have you had as an adult?

Generally, what have they been?

Where do you work now?

How long have you been there?

How do you think things are going for you at work now?

**MEDICAL HISTORY**

Who is your health care provider? _____

When was your last physical exam? _____

Describe any current medical problems or physical symptoms you are having:

List any allergies you have: _____

List all medications you are taking, including reason for use, dosage (if possible) and prescribing doctor:

If you have ever experienced poor reactions to medications, serious illness or injuries, surgeries or head trauma, please describe:

**CHEMICAL USE/ADDICTIONS**

If you drink alcohol, use tobacco or street drugs, at what age did you start? _____

Are you still using? _____

What do you typically use? _____

How often do you use? _____

How much? _____

Do you or other people have any concerns about your use?

Please describe any concerns you might have about your use of prescription medications:

If you gamble (include lottery or pull tabs), please describe:

Are you or others concerned about your gambling?

Have you ever experienced any negative consequences from gambling or use of substances?

Please tell us about any treatment you have had for drug or alcohol abuse, nicotine dependency or gambling (please include dates and where you were treated):

Please tell us about any family members that have had problems with chemical dependency:

**LEGAL HISTORY**

Are you on probation or parole? Yes ☐ No ☐

For what? _____

If yes, have you been ordered by Court/Probation/Parole to attend therapy or treatment?

Have you ever been convicted of a crime or been on probation/parole in the past? Yes ☐ No ☐

What for? _____

List all agencies/people from which you are currently receiving help/services:

**COMMITMENT TO THERAPY**

Please place an X on the line below that shows how ready you are to make changes that will help solve the problem:

**Not at All**..... **Totally Ready**

Comments:

Place an X on the line below that shows how confident you are that you have the skills/knowledge to make the changes:

**Not at All**..... **Totally Ready**

Comments:

Please list the strengths/skills that you already have that will help you make the changes:

What do you think would be helpful from your therapist?

I, the patient, acknowledge that the information provided on this form is correct to the best of my knowledge.

Signature: _____ Date: _____

Zumbro Valley Mental Health Center

# Personal Health Questionnaire Addendum
## Psychiatric Services

Date _____

Name: _____ ID # _____

Name of person completing questionnaire (if not self): _____

Home Phone # _____ Work Phone # _____

May we call you at work? Yes ☐ No ☐ Who referred you? _____

**MEDICAL HISTORY**

Please check the medical problems you are currently experiencing:

| | | |
|---|---|---|
| ☐ Seizures | ☐ Cold sores | ☐ Sexually Transmitted Disease |
| ☐ Liver Problems | ☐ Herpes Simples | ☐ HIV Risk Factors |
| ☐ Thyroid Problems | ☐ Skin Disease/Disorder | ☐ Sexual Difficulties |
| ☐ Cancer | ☐ Heart Disease | ☐ High Cholesterol |
| ☐ Acne | ☐ Stroke | ☐ Kidney Disease |
| ☐ Asthma | ☐ Polycystic Ovarian Disease | ☐ Atopic Dermatitis |
| ☐ Arthritis | ☐ Diabetes | ☐ Glaucoma |
| ☐ Lung Disease | ☐ Heartburn | ☐ Ulcer |
| ☐ Bladder Problems | ☐ Headache | ☐ Osteoporosis |
| ☐ Tuberculosis | ☐ Irregular Periods | ☐ Other Male/Female Disease |
| ☐ Fibromyalgia | | |

Allergies to medicine (please list): _____

Other problems (please list): _____

List all medications you are currently taking, including over-the-counter and herbal treatment (medications, dose, reason used, prescribing doctor:

_____

_____

_____

Please add any other information you would like to provide:

_____

_____

_____

Client Signature: _____ Date: _____

Reviewed by: _____ Date: _____


# Personal Health Questionnaire Addendum
## Psychological Services

| Do you have? | Yes | No | Can we contact? Yes | Can we contact? No | Their Name | Address/Location |
|---|---|---|---|---|---|---|
| 1. Primary care physician | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| 2. Outpatient therapist | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| 3. Outpatient psychiatrist | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| 4. Case manager or social worker | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| 5. Parent or guardian | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| 6. Spouse or significant other | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| 7. Probation or parole officer | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| 8. Personal care attendant | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| 9. In-home health worker | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| 10. School | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| 11. Priest, minister or rabbi | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| 12. Previous treatment facility | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| 13. Adult foster care worker | ☐ | ☐ | ☐ | ☐ | _____ | _____ |
| 14. Chemical health therapist | ☐ | ☐ | ☐ | ☐ | _____ | _____ |

Name: _____ Date: _____