LifeStance HEALTH

# Adult Questionnaire

| PRESENTING PROBLEM – Please briefly describe your concern(s) |
|---|
| |

| CURRENT MEDICATIONS | PAST PSYCHIATRIC MEDS | ALLERGIES |
|---|---|---|
| | | |

**MENTAL HEALTH HISTORY**

Have you had past or current outpatient mental health treatment? ☐ Yes ☐ No
If yes, please specify, include provider and dates of treatment below:

| Type | Provider/Date |
|---|---|
| ☐ Therapy | |
| ☐ Med Management | |
| ☐ Psychological Testing | |
| ☐ Hospitalization for Behavioral Health Reasons | |

**Additional Behavioral Health Information History**

Please provider additional information regarding hospitalizations and medications:

| | |
|---|---|
| **Gender Identity:** | ☐ Male ☐ Female ☐ Trans Male/Trans Man ☐ Trans Female/Trans Woman<br>☐ Genderqueer/Gender Nonconforming<br>☐ Different Identity (please specify): |
| **Sex Assigned at Birth:** | ☐ Male ☐ Female |
| **Sexual Orientation:** | ☐ Heterosexual or Straight ☐ Gay ☐ Lesbian ☐ Bisexual<br>☐ Not Listed Above (please specify): |

**Relationship Status:**

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living with Partner

**Current Living Situation:**

Who is living in the home and their relationship to the patient:

| Cultural/Ethnic/Spiritual Considerations/Identities: | Personal Strengths: |
|---|---|
| | |

☐ **Unknown Family History/Adopted**

**Do you or a family member have a history or prior diagnosis of:**

| | You | Family Members: |
|---|---|---|
| **ADD/ADHD** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather |
| **Anxiety** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather |
| **Bipolar Disorder** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather |
| **Depression** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather |
| **Eating Disorder** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather |
| **Encopresis/Enuresis** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather |
| **Hallucinations/Delusions/Paranoia** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather |
| **OCD** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather |
| **Panic Attacks** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather |
| **Personality Disorder** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather |
| **PTSD/Trauma** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather |
| **Substance Abuse/Dependences** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather |
| **Other:** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather |

**Additional History:**

**MEDICAL HISTORY**

| | |
|---|---|
| **Primary Care Physician:** ☐ Yes ☐ No | **Name/Phone #:** |
| **Date of Last Physician Exam:** | |
| **Date of Last Dental Exam:** | |

| | |
|---|---|
| **Date of Last Vision Exam:** | |
| **Additional Healthcare Providers:**<br>☐ Yes ☐ No | If yes, include name and phone numbers: |

| **Do you or a family member have a history or prior diagnosis of:** | | |
|---|---|---|
| | **You** | **Family Members:** |
| **Asthma** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling<br>☐ Grandmother ☐ Grandfather |
| **Brain Trauma** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling<br>☐ Grandmother ☐ Grandfather |
| **Cancer** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling<br>☐ Grandmother ☐ Grandfather |
| **Diabetes** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling<br>☐ Grandmother ☐ Grandfather |
| **Heart Disease** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling<br>☐ Grandmother ☐ Grandfather |
| **High Blood Pressure** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling<br>☐ Grandmother ☐ Grandfather |
| **Kidney Disease** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling<br>☐ Grandmother ☐ Grandfather |
| **Liver Disease** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling<br>☐ Grandmother ☐ Grandfather |
| **Seizures** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling<br>☐ Grandmother ☐ Grandfather |
| **Stroke** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling<br>☐ Grandmother ☐ Grandfather |
| **Thyroid Problems** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling<br>☐ Grandmother ☐ Grandfather |
| **Other:** | ☐ | ☐ Mother ☐ Father ☐ Child ☐ Sibling<br>☐ Grandmother ☐ Grandfather |

**Additional Past Medical History:**

**SUBSTANCE/ALCOHOL USE HISTORY**

**Alcohol Use:**

Do you drink alcohol? ☐ Yes ☐ No

Number of Times per Week: _____ Number of Drinks: _____

**Smoking History:**

Smoking Status: ☐ Nonsmoker ☐ Ex-smoker ☐ Cigar smoker ☐ Chew tobacco ☐ Current everyday smoker ☐ Current heavy tobacco smoker ☐ Current light tobacco smoker ☐ Pipe smoker ☐ Snuff user

Usage per Day: _____ Number of Years: _____

Do you vape? ☐ Yes ☐ No

Others Smoking in the Home: ☐ Yes ☐ No

**Caffeine Use**

How many drinks containing caffeine do you have on a typical day? ☐ None ☐ 1-2 drinks ☐ 3-4 drinks ☐ 5-6 drinks ☐ 7 or more drinks

**FOOD AND EXERCISE HISTORY**

How often do you exercise? ☐ None ☐ 1-2x/week ☐ 3-4x/week ☐ 5+x/week

Do you have any concerns about your eating or exercise habits? ☐ Yes ☐ No

If yes, please specify:

**EDUCATIONAL HISTORY**

Highest education completed: ☐ Less than grade 12, specific grade: _____ ☐ High School ☐ GED ☐ Trade/Technical School ☐ Some College ☐ Undergraduate Degree ☐ Graduate Degree

Current Student: ☐ Yes ☐ No

If yes, please specify:

OCCUPATIONAL HISTORY

Occupational Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled ☐ Unemployed

Occupation: _____ Length of Current Employment: _____

Employer: _____ How many positions have you held in the past 5 years? _____

**Military Experience:**

Military Experience: ☐ Current ☐ Previous ☐ None

Branch: ☐ Army ☐ Navy ☐ Marines ☐ Air Force ☐ Coast Guard ☐ Other: _____

If other, please describe:

Number of Deployments: _____ Years in Service _____ Discharge Status: ☐ Voluntary ☐ Involuntary

**Thank you for taking the time to complete this questionnaire.**

Completed by: _____ Date Completed: _____

Relationship to Patient: ☐ Self ☐ Patient ☐ Guardian ☐ Adult Child ☐ Other: _____