Oconee Center for Behavioral Health
1360 Caduceus Way
Building 400, Suite 102
Tel 706-286-8442
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Adult Questionnaire

Patient's Name: ____

Date of Birth: _____/_____/_____ Patient's Birthplace: _________________ Sex: ☐M ☐F

Who Referred you to our Practice? ____

Please check all of the behaviors and symptoms that you consider problematic:

☐Distractibility	☐Change in Appetite	☐Suspicion/paranoia
☐Hyperactivity	☐Lack of Motivation	☐Racing Thoughts
☐Impulsivity	☐Withdrawal from people	☐Excessive Energy
☐Boredom	☐Anxiety/Worry	☐Wide mood swings
☐Poor memory/confusion	☐Panic attacks	☐Sleep Problems
☐Seasonal mood changes	☐Fear away from home	☐Nightmares
☐Sadness/depression	☐Social discomfort	☐Eating Problems
☐Loss of pleasure/interest	☐Obsessive thoughts	☐Gambling problems
☐Hopelessness	☐Compulsive behavior	☐Computer addiction
☐Thoughts of death	☐Aggression/fights	☐Problems with pornography
☐Self-harm behaviors	☐Frequent arguments	☐Parenting problems
☐Crying spells	☐Irritability/anger	☐Sexual problems
☐Loneliness	☐Homicidal thoughts	☐Relationship problems
☐Low self-worth	☐Flashbacks	☐Work/school problems
☐Guilt/shame	☐Hearing voices	☐Alcohol/drug use
☐Fatigue	☐Visual hallucinations	☐Recurring,disturbing memories

☐Other: ____________________________________

Please Briefly describe the problems for which you are seeking help at this time:

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____

Approximate date of onset of problems: ____

Have you ever received outpatient mental health treatment? ☐ No ☐ Yes

If yes, please list in order, including Psychological, School, or IQ testing:

Clinician/ Doctor	Approximate Date of Evaluation/Treatment	Type of Evaluation	How Often did you visit said Clinician/Doctor

Have you ever received inpatient mental health treatment? ☐ No ☐ Yes

If yes, please list in order:

Hospital Name	Dates of Treatment	Reason for hospitalization

Have you ever threatened or attempted suicide? ☐ No ☐ Yes

If yes, please explain: ____

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____

Any History of Substance Use or Abuse? ☐ No ☐ Yes ☐ Not Applicable

If yes, please describe your past or current use of any of the following substances:

Substance	Age at time of 1st use	Frequency of use	Amount used	Aprox. Date of last use	Problems leading to use
Alcohol					
Tobacco					
Marijuana					
Cocaine					
Amphetamine					
Ecstasy					
LSD/Acid					
Opiates					
Inhalants					
Hallucinogens					

Family Psychiatric History: Please note any history of ADHD, Learning Disorders, Depression, Bipolar Disorder, Anxiety Disorders, Obsessive-Compulsive Disorder, Tic/ Tourette's,

Schizophrenia, Drug or Alcohol Abuse, Suicide attempts, or other Psychiatric Problems in your grandparents, parents, siblings, or 1st cousins.

Affected Family Member	Type of Mental Illness or SA	Treatment (If Any)

Are you Adopted? ☐ No ☐ Yes

If yes, please explain the circumstances of the adoption: ___________________________

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____

Please Answer the following as best as you can recall:

Motor Development – sitting, crawling, walking, etc. ☐Normal ☐Fast ☐Slow

Speech and Language ☐Normal ☐Fast ☐Slow

Self-Help Skills- dressing, brushing, toileting, hygiene, etc. ☐Normal ☐Fast ☐Slow

Primary Residence as a child: ☐Single Parent Home ☐Two Parent Home ☐Other

Check all that describe your home environment as a child:

☐Nurturing ☐Loving ☐Supportive ☐Abusive

☐Critical ☐Stressful ☐Rigid ☐Harsh Discipline

☐Little Discipline ☐Other

Please Explain Other: ____

____

____

____

Please tell us a little about your social history:

Current City of Residence: ____

Currently Living with: ☐ Spouse ☐Children ☐Roommate ☐Other:

Please Explain Other: ____

Children in Family: ☐ No ☐ Yes If yes, please list:

Name of Child	Age

Marital Status: ☐Single ☐Separated ☐Divorced ☐Married
If Separated, Divorced, or Married how long? ____

Have you ever experienced or witnessed any physical abuse, sexual abuse, or neglect?
☐ No ☐ Yes
If yes, please describe: ____
____
____
____

Please list all previous and current full-time employment:

Position/ Job	Name of Employer	Dates of Employment	Reason for leaving job

If currently employed, do you find satisfaction in your work? ☐ No ☐ Yes

Please tell us a little about your school history:
Highest grade level completed: ________Name of last school attended: ____________________

Current Academic Performance: ☐Good ☐Fair ☐Poor ☐N/A
Past Academic Performance: ☐Good ☐Fair ☐Poor
Past Behavioral Performance: ☐Good ☐Fair ☐Poor

Were you ever in any special education programs? ☐ No ☐ Yes
If yes, please explain: ____
____
____

Any known learning disabilities? ☐ No ☐ Yes
If yes, please explain: ____

Legal Problems:
Have you ever been arrested or had any legal charges files against you? ☐ No ☐ Yes
If yes, please explain: ____
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____
____

Please tell us a little about your medical history:
Who is your Primary Care Doctor? ____
When was your last physical examination? _______________________________________
Do you have any current Medical Problems? ☐ No ☐ Yes
If yes, please explain: ____
____
____
____

If applicable, please list any PAST psychiatric medications:
If we have not provided enough space please feel free to use the bottom or back of this page.

	Medicine #1	Medicine #2	Medicine #3	Medicine #4	Medicine #5
Name of Medicine					
Strength					
How many pills do you take at a time?					
How many times of day do you take this medicine?					
What does this medicine treat?					
Name of prescribing doctor?					

Please list any CURRENT Medications on the last page.

If applicable, please list any CURRENT medications:
If we have not provided enough space please feel free to use the bottom or back of this page.

	Medicine #1	Medicine #2	Medicine #3	Medicine #4	Medicine #5
Name of Medicine					
Strength					
How many pills do you take at a time?					
How many times of day do you take this medicine?					
What does this medicine treat?					
Name of prescribing doctor?					

____ ____________________________________

Patient Signature Date