

WILLIAM MARTIN, PH.D. P.C.
A Professional Corporation
32122 Camino Capistrano Suite 200
San Juan Capistrano, California 92675
(949)248-7377
(866)8052796 fax
[**Billmartinphd@msn.com**](mailto:Billmartinphd@msn.com)

ADULT INITIAL QUESTIONNAIRE

In order to ensure the best care, it's important we find out as much as we can about you. Please read each question carefully and do your best to answer them completely and accurately. Mark "n/a" to questions that do not apply to you.

IDENTIFICATION:

Name _____ Date ___/___/___
(First) (Middle) (Last)

Address _____ Phone _____
(Street) (Apt #)

(City) (State) (Zip)

Age _____ Date of Birth ___/___/___ Male ___ Female ___

Ethnic background: Caucasian ___ African American ___ Asian ___ Hispanic ___
Other (please specify) _____

Who do you live with? Spouse ___ Roommate ___ Parent(s) ___
Children ___ Alone ___

How long have you lived at your present address? _____

Appearance:

Height _____ Weight _____ Hair color _____ Eye color _____

You consider yourself to be: underweight ___ overweight ___ average ___

Your poise and posture is: slumped ___ straight ___

Orientation:

Do you often feel alert and awake? Often ___ Sometimes ___ Rarely ___

Do you find it difficult to orient yourself to : time, place, purpose, and person?
Yes ____ No ____

Mannerisms:

With regards to initial interactions, do you feel you are receptive and easy to maintain rapport with? Yes ____ No ____

Do you exhibit bizarre mannerisms or gestures such as; nervous foot/ finger tapping, twitches, ticks, hand wringing, picking, head shaking or rocking?
No ____ Yes (explain): _____

Do you feel your overall socialized behaviors are appropriate?
Mostly ____ Some of the time ____ Rarely ____

Speech:

Do you have problems with your rate and amount of speech, when talking to others?
Yes ____ No ____

Would you describe your speech as: deliberate____ well modulated____ loud____ soft____
slow____ fast____ slurred____ articulate____

Generally, are your verbal responses relevant to the specific inquires made? Yes____
No____

Affect:

Can you describe your affect (emotions) as: depressed____ apathetic____ elated____
hostile____ anxious____ tearful____ reserved____ negative____
content ____ indifferent ____

Do you feel your emotional responses are appropriate to your thought content? Yes____
No____

Thought Processes:

Have you ever had auditory or visual hallucinations or other delusions of any type?
No____ Yes (explain):_____

Is your thought content sometimes filled with: paranoid/phobic, and/or homicidal/suicidal feelings? No ____ Yes (explain):_____

Have you ever had a head injury? No____ If "Yes", at what age? ____

What best describes your insight into your past and present problems and issues:
limited___ moderate___ substantial___

How would you rate your insight or understanding with regards to the nature of your current problems and the various aspects of your life that have had an influence on your current condition(s)?

1. Limited awareness and knowledge.
2. Fairly aware and knowledgeable?
3. Very aware and knowledgeable?

You'd describe your thought processes as: spontaneous ___ constricted___ Irrelevant ___ poorly organized ___ don't know ___

You consider your general fund of knowledge:
poor ___ adequate ___ exceptional ___

SYMPTOMS

Please check any of the following that you are experiencing.

- | | | |
|--|---|--|
| <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Tiring easily | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Abdominal discomfort | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Feelings of hopelessness | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Lack of interest | <input type="checkbox"/> Racing heart |
| <input type="checkbox"/> Decreased sex drive | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Suicidal feelings |
| <input type="checkbox"/> Hyperventilation | <input type="checkbox"/> Feelings of guilt | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Family problems | <input type="checkbox"/> Shaky inside |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Poor attention span | <input type="checkbox"/> Avoiding people |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Inability to have fun |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Physical complaints | <input type="checkbox"/> Short-tempered |
| <input type="checkbox"/> Crying easily | <input type="checkbox"/> Feelings of inferiority | <input type="checkbox"/> Worrying a lot |
| <input type="checkbox"/> Indecisiveness | <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Inability to relax |
| <input type="checkbox"/> Work problems | <input type="checkbox"/> Seeing things | <input type="checkbox"/> Menstrual changes |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Paranoia | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Personality changes | <input type="checkbox"/> Anger | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Fearfulness | <input type="checkbox"/> Shaky hands |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Phobias | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Socially withdrawn | |

Do you feel your memory is intact? Yes ___ No (explain): _____

PRESENTING PROBLEMS:

Please describe the present problem or situation with which you are requesting assistance (please use the back of this sheet for more room): _____

HISTORY OF PRESENTING PROBLEMS:

With regards to history of presenting problems, please describe any information that pertains to each topic.

Suicidal Ideation:

Alcohol/ Drug abuse:

Child Abuse:

Sexual or Physical Abuse:

If you have had any previous treatment, please list names:

Outpatient Treatment:

Hospitalization:

Other:

MEDICAL HISTORY

Please indicate all medications you are presently taking. _____

Who is your current family physician? _____

How long have you been seeing him/her? _____

Approximately, when was your last visit? _____

Have you ever been diagnosed as having any of the following medical illnesses:

<u>Illness</u>	<u>Date of Diagnosis</u>
Head injury	
Hypertension	
Diabetes	
Hypoglycemia	
Asthma	
Heart Disease	
Seizures	
Neurological	
Thyroid Dysfunction	

If you have been hospitalized for a medical illness, please identify:

<u>Illness</u>	<u>When</u>	<u>Where</u>
1.		
2.		
3.		
4.		
5.		

If you have any known allergies to the following, please specify:

Food:

Drugs:

Other:

If you have ever acquired any of the following childhood diseases, please indicate and specify when:

<u>Disease</u>	<u>When</u>
Measles	
Mumps	
Chicken Pox	
Recent Exposure	

Currently, do you frequently use any of the following:

		<u>Amount</u>	<u>Frequency</u>
Alcohol:	Yes___ No___	_____	_____
Drugs:	Yes___ No___	_____	_____
Tobacco:	Yes___ No___	_____	_____

DEVELOPMENTAL HISTORY

Were there any complications that happened during your birth?

Please give a brief summary of your:

Childhood:

Adolescence:

Adulthood:

FAMILY HISTORY:

What is your father's name? _____

If deceased, what year did he die, at what age, and cause of death? _____

Where does your father currently live? _____

What is/ was your father's occupation? _____

Please briefly describe the characteristics of your father.

Please describe your relationship with your father (i.e., is it: distant, close, strained). _____

What is your mother's name? _____

If deceased, what year did she die, at what age, and what was the cause of death? _____

Where does your mother currently live? _____

What is/was your mother's occupation? _____

Please briefly describe the characteristics of your mother.

Please describe your relationship with your mother:

Siblings:

Name Birthdate or Age

- 1.
- 2.
- 3.
- 4.
- 5.

Please describe your relationship with each of your siblings.

MARITAL/ RELATIONSHIP HISTORY

When and where did you first meet your spouse?

When did you get married? _____

Please describe your relationship with your spouse. _____

Children:

Names Birthdates

- 1.
- 2.
- 3.
- 4.
- 5.

Please describe your relationship with each of your children. _____

SOCIAL HISTORY:

With regards to social history, please briefly describe any information that pertains to each topic.

Friendships: _____

Socialization trends: _____

Childhood Socialization: _____

Hobbies/Interests: _____

Religious Affiliations: _____

Support Systems: _____

EDUCATIONAL HISTORY:

What kind of grades did you receive during elementary school? ____
Junior High? ____ High School? ____

Did you identify any learning disabilities? ____ If "Yes," what were they? _____

Name of Elementary school attended: _____ City _____ State ____
What best describes you during Elementary School? shy ____ friendly ____
popular ____ had many friends ____ had few friends ____ alienated ____

Name of Junior High attended: _____ City _____ State ____
What best describes you during Junior High School? Shy ____ friendly ____ popular ____
had many friends ____ had few friends ____ alienated ____

Name of High School attended: _____ City _____ State ____
What best describes you during High School? Shy ____ friendly ____ popular ____ had
many friends ____ had few friends ____ alienated ____
When did you graduate from High School? _____

What college(s) /university(ies) did you attend? _____

When did you attend? From _____ to _____
Did you receive a degree? ____ If "Yes," what kind of degree(s)? _____

What kind of grades did you receive during college? (i.e., good, fair, poor). ____

What best describes you during college? Shy____ friendly____ popular____ had many friends____ had few friends____ alienated ____

OCCUPATIONAL HISTORY:

If you are currently working, who is your employer? _____

When did you first start this job? _____

What are your job duties? _____

Briefly describe your work history; (include company, city, state, years of service and salary.) _____

Is there anything else you'd like to share?

How long did it take you to fill out this questionnaire?

Do you have comments about his questionnaire?