Nashville Child and Family Wellness Center
Adult Initial Visit Questionnaire

Understanding as much as possible about you is essential to the success of your treatment. Please answer these questions as honestly as you can, and feel free to explain or add any other information. If a question does not apply to you or your situation, please write N/A. ***This information, like ALL information you provide, is confidential and will be reviewed only by the provider you are scheduled to see or those for whom you give consent to review this.***

Provider you are scheduled to see:____

Your Name: ____Today's Date: __________________
Your Age: ___________________ Date of Birth: ________________________ Sex: ☐ Female ☐ Male
Home Address:
Street:____
City: ___________________________________ State:_________ Zip________________
Emergency Contact: ________________________ Relation:________________Phone:_______________

FAMILY INFORMATION:
Relationship status:

☐ single ☐ dating ☐ married ☐ remarried ☐ partnered ☐ divorced ☐ separated ☐ widowed

If married, remarried, partnered, divorced or separated, please provide date (s): _________________

Date of present marriage: __________ # of previous marriages: _______

Please list the people you live with (e.g., parents, siblings, partner/spouse, children, etc.)

Name	Relationship	Age & DOB	Sex (M/F)	Quality of Relationship

Please list any other significant people in your life:

Name	Relationship	Age & DOB	Sex (M/F)	Quality of Relationship

SOCIAL HISTORY:
What is the highest educational level you have completed? ☐ High School Degree ☐ 2 year college degree ☐ 4 year college degree ☐ Graduate School ☐ Other:_____ ___________________________

Nashville Child and Family Wellness Center is a collection of independently practicing professionals, none of whom are responsible for the acts or omissions of the others.

Are you currently in school? ☐ Yes ☐ No

Are you currently working? ☐ No ☐ Yes If yes, describe:

Occupation ____(check one) ☐ Satisfied ☐ Dissatisfied

Employer____ (check one) ☐ Full-Time ☐ Part-Time

Do you get regular exercise or play sports? ☐ No ☐ Yes If yes, describe: __________________________

____

What do you like to do in your free time? ____

What is your religious preference, if any? ____

Do you have any past or current legal issues or concerns? ☐ No ☐ Yes If yes, please explain:___________

____

MEDICAL AND MENTAL HEALTH HISTORY:

Primary Care Doctor Name:____

Phone Number: ____________________________ Date last seen:__________________________________

Referring Doctor Name:____

Phone Number: ____________________________ Date last seen:__________________________________

Medications:

Are you allergic to any medications: ☐ No ☐ Yes

If yes, please list medication(s) and type of reaction:

____

____

Please list any medications you currently take, including any vitamins or supplements.

Medication	Dose	Frequency	Reason Taking	Person Prescribing

Have you ever been prescribed any medications for mental health concerns? ☐ No ☐ Yes

If yes, please describe below unless already described above:

Medication	Dose	Frequency	Reason for Taking	Negative Reaction? (Y/N)

Please list any current medical problems, including when diagnosed (if unsure, provide approx. age):

Medical problem Date of Diagnosis

____

____

____

____

Any Hospitalizations? ☐ No ☐ Yes If yes, please provide reason and date (if unsure, give approx. age):

Reason for Hospitalization Date(s) Hospitalized

____

____

Any surgeries? ☐ No ☐ Yes If yes, please provide details:

Surgical Procedure Date of surgery (if unsure, provide approx. age)

____

____

Do you see any other doctor on a regular basis? ☐ No ☐ Yes If yes, please provide details:

Name: Phone Number Date Last Seen

____

____

____

Please indicate if you or anyone in your family (include siblings, parents, grandparent, aunts, uncles, and cousins) have a history of (check all that apply and indicate relationship to family member where applicable):

Self Family

☐ ☐ High blood pressure ____

☐ ☐ High cholesterol ____

☐ ☐ Heart attack (age occurred) ____

☐ ☐ Other heart disease ____

☐ ☐ Asthma, other lung problems ____

☐ ☐ Stroke ____

☐ ☐ Blood clots/bleeding disorder ____

☐ ☐ Migraines/other neurologic ____

☐ ☐ Cancer (list type) ____

☐ ☐ Diabetes ____

☐ ☐ Thyroid disease ____

☐ ☐ Head Injury ____

☐ ☐ Seizures ____

☐ ☐ Depression ____

☐ ☐ Bipolar disorder ____

☐ ☐ Anxiety/OCD ____

☐ ☐ ADHD ____

☐ ☐ Autism/Asperger's ____

☐ ☐ Schizophrenia or other psychotic disorder ____________________________

☐ ☐ Suicide ____

☐ ☐ Alcoholism/Drug Abuse ______________________________________

☐ ☐ Sexual Abuse ____

☐ ☐ Physical Abuse ____

☐ ☐ Emotional Abuse ____

☐ ☐ Neglect ____

☐ ☐ Domestic Violence _______________________________________

☐ ☐ DCS Involvement ____

☐ ☐ Frequent Moving ____

☐ ☐ Homelessness ____

☐ ☐ Criminal History ____

☐ ☐ Other (explain) ____

Explain any items that were checked:

____

____

____

____

List any other major life stressors (e.g., death of family member, unemployment, major accident, house fire, crime victim, etc.) that you have faced during your life and when:

____

____

Have you ever required hospitalization for mental health reasons? ☐ No ☐ Yes

If yes, please provide details:

Date(s) (if unknown approx. age) Reason

____

____

Have you ever tried to kill yourself or engaged in self-harming behavior (i.e. cutting, head banging, other)? ☐ No ☐ Yes If yes, please explain: ___________________________

____

Have you previously seen a mental health professional (therapist/ counselor/ psychologist/ psychiatrist)?

☐ No ☐ Yes If yes, please describe below:

Age Start/Stop # meetings Provider Name Provider Type Reason

____

____

____

____

____

____

List any significant life influences not yet described:____
____
____

SPEECH/LANGUAGE SECTION

Do you have trouble finding the exact words to say when speaking or writing?

☐ No ☐ Yes If yes, how early? _____________________________

Is it hard for you to follow complex directions?

☐ No ☐ Yes If yes, how early? ____________________________

Is it difficult for you to keep information in your memory long enough to complete a task? (i.e. a math problem, shopping list)

☐ No ☐ Yes If yes, how early? _____________________________

Do you have difficulty understanding jokes, humor, and figurative language?

☐ No ☐ Yes If yes, how early? _____________________________

Do you have difficulty interacting with others like starting a conversation, maintaining a conversation or ending a conversation?

☐ No ☐ Yes If yes, how early? _____________________________

Do you have difficulty keeping yourself organized?

☐ No ☐ Yes If yes, how early? _____________________________

CURRENT VISIT:

For what issues are you currently seeking help and when did they start? ___________________________
____
____

What kind of help do you expect from your treatment at Nashville Child and Family Wellness Center?
____
____

How long do you expect treatment for the current issue(s) to last?________________________________
____

Any other comments? ____
____
____

CURRENT SYMPTOM CHECKLIST

Please place a check mark in the box next to any symptom you are currently experiencing or have experienced in the past few weeks.

- ☐ Sleep problems
- ☐ Sleep too much
- ☐ Nightmares or night terrors
- ☐ Feel a sense of dread
- ☐ Feel I have no future
- ☐ Isolation/social withdrawal
- ☐ Mood swings
- ☐ Lower sex drive
- ☐ Agitation or nervousness
- ☐ Muscle tension or soreness
- ☐ Stomach nausea or upset
- ☐ Having to check and re-check
- ☐ Worry about what others think
- ☐ Compare self to others
- ☐ Obsessive thoughts
- ☐ Compulsive behaviors
- ☐ Feel my life is out of control
- ☐ Afraid something is wrong w/ me
- ☐ Faintness or dizziness
- ☐ Easily annoyed or irritated
- ☐ Pain in heart or chest
- ☐ Feel over-sensitive
- ☐ Heart pounds or races
- ☐ Feel inferior to others
- ☐ Difficulty making decisions
- ☐ Afraid to go out in public
- ☐ Avoid certain things
- ☐ Have frightening/disturbing thoughts
- ☐ Feel something bad will happen
- ☐ Have unfounded fears
- ☐ Worry a lot
- ☐ Feel hopeless/helpless
- ☐ Appetite changes
- ☐ Excessive behaviors (spending, gambling, etc)
- ☐ Racing thoughts
- ☐ Frequent headaches
- ☐ Feel panicky or terrified
- ☐ Uncomfortable memories
- ☐ Feel disconnected from reality
- ☐ Dislike my body
- ☐ Feel guilty or ashamed
- ☐ Cry often
- ☐ Feel life is not worth living
- ☐ Temper outbursts
- ☐ Low energy
- ☐ Withdrawn socially
- ☐ Body aches and pains
- ☐ Feel lonely
- ☐ Perfectionist
- ☐ Shortness of breath
- ☐ Enjoy things less
- ☐ Self-conscious
- ☐ Fearful when driving
- ☐ Trouble concentrating
- ☐ Feel worthless
- ☐ Argumentative
- ☐ Dislike crowds
- ☐ Difficulty remembering things
- ☐ Feel suicidal
- ☐ Low self-esteem
- ☐ Stress or tension
- ☐ Thoughts of hurting yourself
- ☐ Thoughts of hurting someone
- ☐ Cutting or self-injury
- ☐ Alcohol or drug use
- ☐ Prescription drug abuse
- ☐ Anger management
- ☐ Blackouts
- ☐ Eating concerns/body image
- ☐ Depression/sadness
- ☐ Access to gun or firearms
- ☐ Other (list below)

Please list any other symptoms that would be helpful for me to know:

Nashville Child and Family Wellness Center is a collection of independently practicing professionals, none of whom are responsible for the acts or omissions of the others.