

## 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: \_\_\_\_\_

### **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.)

<u>Name</u>	<u>Relationship</u>	<u>Age &amp; DOB</u>	<u>Sex (M/F)</u>	<u>Quality of Relationship</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list any other significant people in your life:

<u>Name</u>	<u>Relationship</u>	<u>Age &amp; DOB</u>	<u>Sex (M/F)</u>	<u>Quality of Relationship</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

### **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: \_\_\_\_\_

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: \_\_\_\_\_

**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
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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)
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Medical problem	Date of Diagnosis
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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:

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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:

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

If yes, please provide details:

Date(s) (if unknown approx. age)	Reason
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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: \_\_\_\_\_

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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
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List any significant life influences not yet described: \_\_\_\_\_

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**CURRENT VISIT:**

For what issues are you currently seeking help and when did they start? \_\_\_\_\_

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

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

Any other comments? \_\_\_\_\_

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