

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.)

<u>Name</u>	<u>Relationship</u>	<u>Age & 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 & 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: _____

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
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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
_____	_____
_____	_____
_____	_____

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
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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.

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 Withdrawn socially |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

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