SHADOW MOUNTAIN
BEHAVIORAL HEALTH SYSTEM

OUTPATIENT SERVICES
ADULT HISTORY AND GOALS QUESTIONNAIRE

Please complete this questionnaire and give it to your physician at your first appointment. This information will help your clinician gain an understanding of the problems for which you are seeking help and other important events in your life.

YOUR NAME IN FULL	DATE OF BIRTH	AGE

WHO REFERRED YOU TO SHADOW MOUNTAIN BHS	TODAY'S DATE

WHAT EMOTIONAL BEHAVIORAL OR INTERPERSONAL PROBLEMS ARE YOU EXPERIENCING

HOW LONG HAVE THESE PROBLEMS BEEN AFFECTING YOUR LIFE

IF APPLICABLE, DESCRIBE HOW THE PROBLEMS ARE INTERFERING WITH WORK OR SCHOOL PERFORMANCE, FAMILY LIFE, SOCIAL LIFE, RELATIONSHIPS, YOUR ABILITY TO CARRY OUT ACTIVITIES OF DAILY LIVING LIKE CHORES AND BATHING

DESCRIBE ANY STRESSFUL CIRCUMSTANCES YOU ARE EXPERIENCING THAT MAY BE CONTRIBUTING TO THESE PROBLEMS

WHAT HAVE YOU DONE TO TRY TO SOLVE THESE PROBLEMS

PREVIOUS TREATMENT

HAVE YOU RECEIVED PREVIOUS TREATMENT FOR MENTAL HEALTH PROBLEMS? ☐ NO ☐ YES (describe below)

DATE	NAME OF FACILITY OR PROFESSIONAL	TYPES OF TREATMENT (Medication, Psychotherapy, Hospitalization, etc.)	RESPONSE

WHAT DID YOU FIND MOST HELPFUL ABOUT YOUR PREVIOUS TREATMENT

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SUBSTANCE ABUSE

DESCRIBE YOUR USE OF THE FOLLOWING SUBSTANCES	AGE WHEN FIRST USED	PREVIOUS USE		CURRENT USE	
		FREQUENCY	QUANTITY	FREQUENCY	QUANTITY
CAFFEINE					
CIGARETTES / OTHER NICOTINE					
ALCOHOL					
MARIJUANA					
COCAINE					
METHAMPHETAMINES					
OPIATES					
OTHER					

	YES	NO
DO YOU SOMETIMES USE MORE THAN YOU PLANNED OF ONE OF THE PREVIOUS SUBSTANCES?		
DO YOU FIND YOURSELF FREQUENTLY THINKING ABOUT OR PREOCCUPIED WITH ONE OF THESE SUBSTANCES?		
HAS A FAMILY MEMBER OR FRIEND EVER EXPRESSED CONCERN ABOUT YOUR ALCOHOL / DRUG USE?		
HAVE YOU EVER MISSED SCHOOL OR WORK BECAUSE OF INTOXICATION OR A HANGOVER?		
HAVE YOU EVER TRIED TO STOP USING DRUGS OR ALCOHOL WITHOUT SUCCESS?		
HAVE YOU EVER EXPERIENCED LEGAL PROBLEMS (ARRESTS, DUIs) FOR YOUR BEHAVIOR WHILE UNDER THE INFLUENCE OF ALCOHOL OR DRUGS?		
HAVE YOU EVER BEEN UNDER TREATMENT FOR ALCOHOL OR SUBSTANCE ABUSE PROBLEMS?		

COMMENTS

MEDICAL HISTORY

HAVE YOU HAD ANY PROBLEMS WITH BIRTH OR EARLY DEVELOPMENT

AS A CHILD OR ADOESCENT, DID YOU EXPERIENCE ANY OF THE FOLLOWING

	NO	YES	DESCRIBE
PHYSICAL ABUSE			
SEXUAL ABUSE			
LOSS OF PARENT			
OTHER TRAUMA			

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WHAT WAS IT LIKE TO GROW UP IN YOUR FAMILY? DESCRIBE ANY SIGNIFICANT EVENTS THAT YOU THINK MIGHT BE IMPORTANT IN UNDERSTANDING OR SOLVING THE PROBLEMS THAT YOU BRING TO TREATMENT

LIST ANY FAMILY MEMBERS THAT HAVE BEEN TREATED FOR MENTAL DISORDERS SUCH AS SCHIZOPHRENIA, DEPRESSION, MANIC DEPRESSION, ALCOHOL / DRUG ADDICTION, ATTENTION DEFICIT DISORDER OR SEVERE ANXIETY DISORDER AND INDICATE THE TYPES OF TREATMENT THEY RECEIVED (FOR EXAMPLE: PSYCHOTHERAPY, MEDICATION, HOSPITALIZATION)

FAMILY MEMBER	DISORDER	TYPE OF TREATMENT

RELATIONSHIPS

DESCRIBE YOUR CURRENT FAMILY SITUATION	MARITAL STATUS

WHO LIVES IN YOUR HOME

HOW MANY CLOSE FRIENDS DO YOU HAVE	DESCRIBE PROBLEMS, IF ANY, YOU THINK YOU HAVE IN DEVELOPING AND KEEPING FRIENDSHIPS
ARE YOU SATISIFED WITH THIS NUMBER ☐ Yes ☐ No	DESCRIBE PROBLEMS, IF ANY, YOU THINK YOU HAVE IN DEVELOPING AND KEEPING INTIMATE RELATIONSHIPS

HAS THERE BEEN ANY VIOLENCE IN YOUR CURRENT FAMILY / SIGNIFIGANT RELATIONSHIP (INCLUDING PUSHING, SHOVING, RESTRAINING, HITTING, THREATENING OR INTIMIDATING GESTURES)
☐ Yes ☐ No

HAVE YOU EXPERIENCED VIOLENCE IN PAST RELATIONSHIPS
☐ Yes ☐ No

EDUCATION AND EMPLOYMENT

LIST ANY RECENT CHANGES

EDUCATION	☐ Completed high school ☐ Completed college	☐ Did not complete high school ☐ Completed graduate training	☐ Completed business / technical training
OCCUPATION	☐ Homemaker ☐ Professional	☐ Technical / Trade ☐ Unemployed	☐ Sales ☐ Other

MILITARY SERVICE	BRANCH	HIGHEST RANK	TYPE OF DISCHARGE
☐ Yes ☐ No			

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MEANING AND SPIRITUALITY

WHAT GIVES YOUR LIFE MEANING

IS SPIRITUALITY OR RELIGION A SIGNIFICANT PART OF YOUR LIFE ☐ YES ☐ NO	DO YOU PARTICIPATE IN A SPIRITUAL COMMUNITY ☐ YES ☐ NO
WHAT RELIGION OR DENOMINATION DO YOU IDENTIFY WITH	HOW ACTIVE ARE YOU IN THIS COMMUNITY

OTHER IMPORTANT INFORMATION

RACE ☐ ASIAN ☐ CAUCASIAN ☐ AFRICAN AMERICAN
☐ HISPANIC ☐ NATIVE AMERICAN ☐ OTHER (specify)

IF APPLICABLE, DESCRIBE ANY FINANCIAL DIFFICULTIES YOU ARE HAVING

LIST WHAT YOU DO FOR FUN OR RECREATION (HOBBIES, PARTICIPATE IN SOCIAL ACTIVITIES SUCH AS CLUBS, SPECIAL INTEREST GROUPS, ETC)

WHAT AREAS OF YOUR LIFE ARE MOST SATISFYING TO YOU (E.G. CAREER, PARENTING, FRIENDSHIPS)

GOALS AND EXPECTATATIONS

WHAT TYPE OF TREATMENT DO YOU HOPE TO RECEIVE FROM SHADOW MOUNTAIN BEHAVIORAL HEALTH SERVICES
☐ Assessment and consultation ☐ Medication ☐ Individual psychotherapy
☐ Marital or Family Therapy ☐ Specify Other:

DESCRIBE YOUR GOALS FOR TREATMENT

DURING THE COMING WEEKS, WHAT SUPPORT SYSTEMS WILL BE AVAILABLE TO HELP YOU DEAL WITH THESE PROBLEMS (FRIENDS, RELATIVES, NEIGHBORS, CHURCH ORGANIZATIONS, ETC)

REVIEWED BY (CLINICIAN'S SIGNATURE)	CREDENTIALS	DATE

THIS PATIENT **DOES** **DOES NOT** REQUIRE A PHYSICAL EXAMINATION