**ReBalance Therapy**

Mind. Body. Soul.

**Adult Questionnaire**

*\*This form is Completely Confidential*

*If your symptoms intensify before your dated appointment, please call 911 or go to the emergency room.*

*Please fill out each section to the best of your ability prior to your therapy session. The following information will be reviewed by your therapist.*

Presenting Problem (briefly describe your concerns):

Current Medications (please list any current medications and daily dosage -over the counter, vitamins, herbs, and supplements):

Past Psychiatric Medications (please include beneficial side effects, side effects, reason it was discontinued, when and how long you took the medication:

Past Psychiatric Treatment and History including Interventional Psychiatry History:

Have you ever been hospitalized or in an in-patient facility for a mental health issue? Yes/no

Have you ever attempted suicide? Yes/No

Are you currently experiencing suicidal thoughts or have a plan to harm yourself? Yes/No

Allergies:

**Behavioral Health History**

Have you had past or current outpatient mental health treatment (please circle): Yes No

 Provider/Date

|  |  |
| --- | --- |
| Therapy |  |
| Med Management  |  |
| Psychological Testing |  |
| Hospitalization for Behavioral Health Reasons |  |

Additional Behavioral Health History:

Gender Identity:

Sex Assigned at Birth:

Sexual Orientation:

Relationship Status:

Current Living Situation (who is living in the home and their relationship to the patient):

Cultural/Ethical/Spiritual Considerations/Identities:

Personal Strengths:

Do you or a family member have a history or prior diagnosis of (please circle all that apply):

|  |  |  |  |
| --- | --- | --- | --- |
| ADD/ADHD | You | Family Member  | Sis/bro/mom/dad/other |
| Anxiety | You | Family Member  | Sis/bro/mom/dad/other |
| Bipolar Disorder | You | Family Member  | Sis/bro/mom/dad/other |
| Depression | You | Family Member | Sis/bro/mom/dad/other |
| Eating Disorder | You | Family Member | Sis/bro/mom/dad/other |
| Encopresis/Enuresis | You | Family Member  | Sis/bro/mom/dad/other |
| Hallucinations/Delusions/Paranoia | You | Family Member | Sis/bro/mom/dad/other |
| OCD | You | Family Member | Sis/bro/mom/dad/other |
| Panic Attacks | You | Family Member  | Sis/bro/mom/dad/other |
| Personality Disorder | You | Family Member | Sis/bro/mom/dad/other |
| PTSD/Trauma | You | Family Member | Sis/bro/mom/dad/other |
| Substance Abuse/Dependence  | You | Family Member | Sis/bro/mom/dad/other |
| Other | You | Family Member  | Sis/bro/mom/dad |
| Other | You | Family Member | Sis/bro/mom/dad |

Additional History:

**Medical History**

Primary Care Physician (please circle): Yes No

 Name/Phone:

 Date of last physical exam:

 Date of last dental exam:

 Date of last vision exam:

Additional healthcare providers (please circle): Yes No

Are you currently experiencing any pain (please circle): Yes No

If yes, please indicate onset, duration, location, intensity rating, aggravating factors, alleviating factors, and related symptoms):

Acute (less than 1 month) Subacute (1-3 months) Chronic (more than 3 months)

Do you or a family member have a history or prior diagnosis of:

|  |  |  |  |
| --- | --- | --- | --- |
| Asthma | You | Family Member  | Sis/bro/mom/dad/other |
| Cancer | You | Family Member | Sis/bro/mom/dad/other |
| Concussion/Head Injury | You | Family Member | Sis/bro/mom/dad/other |
| Diabetes | You | Family Member | Sis/bro/mom/dad/other |
| Dyslipidemia | You | Family Member | Sis/bro/mom/dad/other |
| Endocrine Disorder | You | Family Member | Sis/bro/mom/dad/other |
| Heart Disease  | You | Family Member | Sis/bro/mom/dad/other |
| High Blood Pressure | You | Family Member | Sis/bro/mom/dad/other |
| Kidney Disease | You | Family Member | Sis/bro/mom/dad/other |
| Liver Disease  | You | Family Member | Sis/bro/mom/dad/other |
| Seizures | You | Family Member | Sis/bro/mom/dad/other |
| Stroke | You | Family Member  | Sis/bro/mom/dad/other |
| Thyroid Problems | You | Family Member | Sis/bro/mom/dad/other |
| Other | You | Family Member  | Sis/bro/mom/dad/other |

Any additional past medical history:

**Tobacco / Alcohol / Prescription Medication / Other Substance Use**

1. In the past 12 months, how often have you used tobacco (e-cigarette, vaping, or chewing tobacco)?
2. In the past 12 months, how often have you had 5 or more drinks containing alcohol in one day?
3. In the past 12 months, how often have you used any prescription medications just for the feeling, more than prescribed or that were not prescribed for you?
4. In the past 12 months, how often have you used any drugs including marijuana, cocaine, or crack, heroin, methamphetamine, hallucinogens, ecstasy/MDMA?

Caffeine:

How many drinks containing caffeine do you have on a typical day:

Food / Exercise History:

How often do you exercise?

Do you have any concerns about your eating or exercise habits (if yes, please specify)

Educational History:

Highest education completed (less than grade 12, specify grade:

Current Student (please circle): Yes No

Occupational History (please circle): Full Time Part-time Retired Disabled Unemployed

Occupation:

Length of Employment:

Employer:

How many positions have you held in the past 5 years:

Military Experience (please circle): Current Previous None

Army Navy Marines Air Force Coast Guard Reserves Other

Number of deployments:

Years in service:

Discharge status (please circle): Voluntary Involuntary

**Thank you for completing this questionnaire**

**Completed by: Date:**

**Relationship to patient (please circle): Self Parent Guardian Adult Child**