LifeStance HEALTH

Adult Questionnaire

PRESENTING PROBLEM – Please briefly describe your concern(s)

CURRENT MEDICATIONS	PAST PSYCHIATRIC MEDS	ALLERGIES

MENTAL HEALTH HISTORY

Have you had past or current outpatient mental health treatment? ☐ Yes ☐ No
If yes, please specify, include provider and dates of treatment below:

Type	Provider/Date
☐ Therapy	
☐ Med Management	
☐ Psychological Testing	
☐ Hospitalization for Behavioral Health Reasons	

Additional Behavioral Health Information History

Please provider additional information regarding hospitalizations and medications:

Gender Identity:	☐ Male ☐ Female ☐ Trans Male/Trans Man ☐ Trans Female/Trans Woman ☐ Genderqueer/Gender Nonconforming ☐ Different Identity (please specify):
Sex Assigned at Birth:	☐ Male ☐ Female
Sexual Orientation:	☐ Heterosexual or Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Not Listed Above (please specify):

Relationship Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living with Partner

Current Living Situation:

Who is living in the home and their relationship to the patient:

Cultural/Ethnic/Spiritual Considerations/Identities:	Personal Strengths:

☐ **Unknown Family History/Adopted**

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

	You	Family Members:
ADD/ADHD	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Anxiety	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Bipolar Disorder	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Depression	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Eating Disorder	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Encopresis/Enuresis	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Hallucinations/Delusions/Paranoia	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
OCD	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Panic Attacks	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Personality Disorder	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
PTSD/Trauma	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Substance Abuse/Dependences	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Other:	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather

Additional History:

MEDICAL HISTORY

Primary Care Physician: ☐ Yes ☐ No	**Name/Phone #:**
Date of Last Physician Exam:	
Date of Last Dental Exam:	

Date of Last Vision Exam:	
Additional Healthcare Providers: ☐ Yes ☐ No	If yes, include name and phone numbers:

Do you or a family member have a history or prior diagnosis of:		
	You	**Family Members:**
Asthma	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Brain Trauma	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Cancer	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Diabetes	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Heart Disease	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
High Blood Pressure	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Kidney Disease	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Liver Disease	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Seizures	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Stroke	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Thyroid Problems	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Other:	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather

Additional Past Medical History:

SUBSTANCE/ALCOHOL USE HISTORY

Alcohol Use:

Do you drink alcohol? ☐ Yes ☐ No

Number of Times per Week: _____ Number of Drinks: _____

Smoking History:

Smoking Status: ☐ Nonsmoker ☐ Ex-smoker ☐ Cigar smoker ☐ Chew tobacco ☐ Current everyday smoker ☐ Current heavy tobacco smoker ☐ Current light tobacco smoker ☐ Pipe smoker ☐ Snuff user

Usage per Day: _____ Number of Years: _____

Do you vape? ☐ Yes ☐ No

Others Smoking in the Home: ☐ Yes ☐ No

Caffeine Use

How many drinks containing caffeine do you have on a typical day? ☐ None ☐ 1-2 drinks ☐ 3-4 drinks ☐ 5-6 drinks ☐ 7 or more drinks

FOOD AND EXERCISE HISTORY

How often do you exercise? ☐ None ☐ 1-2x/week ☐ 3-4x/week ☐ 5+x/week

Do you have any concerns about your eating or exercise habits? ☐ Yes ☐ No

If yes, please specify:

EDUCATIONAL HISTORY

Highest education completed: ☐ Less than grade 12, specific grade: _____ ☐ High School ☐ GED ☐ Trade/Technical School ☐ Some College ☐ Undergraduate Degree ☐ Graduate Degree

Current Student: ☐ Yes ☐ No

If yes, please specify:

OCCUPATIONAL HISTORY

Occupational Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled ☐ Unemployed

Occupation: _____ Length of Current Employment: _____

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

Military Experience:

Military Experience: ☐ Current ☐ Previous ☐ None

Branch: ☐ Army ☐ Navy ☐ Marines ☐ Air Force ☐ Coast Guard ☐ Other: _____

If other, please describe:

Number of Deployments: _____ Years in Service _____ Discharge Status: ☐ Voluntary ☐ Involuntary

Thank you for taking the time to complete this questionnaire.

Completed by: _____ Date Completed: _____

Relationship to Patient: ☐ Self ☐ Patient ☐ Guardian ☐ Adult Child ☐ Other: _____