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Date Completed: \_\_\_\_\_

**ADULT Questionnaire**

Name: \_\_\_\_\_ M F Age: \_\_\_\_\_ DOB: \_\_\_\_\_ S.S.#: \_\_\_\_\_

Home Ph. #: \_\_\_\_\_ Cell Ph.#: \_\_\_\_\_

Address: \_\_\_\_\_

Marital Status: (Please circle) Single Married Separated Divorced Living Together

Date of Current Marriage: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Ph.# \_\_\_\_\_

Employer: \_\_\_\_\_ Ph.# \_\_\_\_\_

Address: \_\_\_\_\_

**MEDICAL INFORMATION:**

PCP/Practice: \_\_\_\_\_ Ph. #: \_\_\_\_\_

Address: \_\_\_\_\_

Physician/Practice: \_\_\_\_\_ Ph. #: \_\_\_\_\_

Address: \_\_\_\_\_

Allergies: \_\_\_\_\_

Current Medical Problems

Current Medications

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Person Responsible for Payment: \_\_\_\_\_

Who referred you to this practice: \_\_\_\_\_

Why? \_\_\_\_\_

Do you agree with this referral? Y N Mixed Feelings

If no, why? \_\_\_\_\_

If a thank you is appropriate, please provide their address & phone #: \_\_\_\_\_

What is the reason you are seeking our services?

Current Working Situation:

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**FAMILY INFORMATION**

If partnered, for how long: \_\_\_\_\_ If married, since when: \_\_\_\_\_

- If separated, divorced or a partner has died, on the back of this page please explain the circumstances, custody & visitation schedule (if any) and communication status between parents.
- Please give a brief history below as to when you and your partner or spouse first met, and any relevant information about your years together (what life crises or challenges or joys you both have experienced).

Spouse/Partner Name: \_\_\_\_\_ M F DOB: \_\_\_\_\_  
S.S.# \_\_\_\_\_ Home Ph.: \_\_\_\_\_ Cell: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Address: \_\_\_\_\_

Other Household Members:

| Name  | DOB   | Relationship |
|-------|-------|--------------|
| _____ | _____ | _____        |
| _____ | _____ | _____        |
| _____ | _____ | _____        |
| _____ | _____ | _____        |
| _____ | _____ | _____        |
| _____ | _____ | _____        |
| _____ | _____ | _____        |

Children Residing Elsewhere:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

If you have a child or children with any significant health, learning problem or emotional history please provide details below:

**Your Family of Origin**

(If you were adopted, please give any relevant information about biological parent history.)

Mother's name, Country of Origin and Educational Background:

\_\_\_\_\_  
\_\_\_\_\_

Did she have any physical, learning or emotional problems?

\_\_\_\_\_  
\_\_\_\_\_

Her Religious/Spiritual Affiliation (if any): \_\_\_\_\_

Her work experience (if any outside the home):

\_\_\_\_\_  
\_\_\_\_\_

Father's name, Country of Origin and Educational Background:

\_\_\_\_\_  
\_\_\_\_\_

Did he have any physical, learning or emotional problems?

\_\_\_\_\_  
\_\_\_\_\_

His religious/spiritual affiliation (if any): \_\_\_\_\_

His work experience: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Brothers/Sisters:

Biological?

Quality of this

Health

Name                      Yes/No (Explain)                      Relationship                      Age                      M/F                      Status

Please list anyone else who lived with you or was a memorable caretaker for you as you were growing up:

| <u>Name</u> | <u>Age</u> | <u>Relationship</u> | <u>Quality of this Relationship</u> | <u>Health/Problems</u> |
|-------------|------------|---------------------|-------------------------------------|------------------------|
|-------------|------------|---------------------|-------------------------------------|------------------------|

### **Medical Health History**

Have you experienced any serious accidents/injuries/illnesses involving such things as (circle):  
Convulsions, high fevers, loss of consciousness, fainting, headaches, allergies, chronic fatigue, head injuries, ear problems, meningitis

Any others? Please describe:

Did you ever require hospitalization or have been treated for serious illness or disease? If so, please explain:

When was your last complete physical?

### **Mental Health History**

Have you ever had:

Previous individual counseling? Y/N

If yes:

Reason \_\_\_\_\_

Therapist location \_\_\_\_\_

Diagnosis \_\_\_\_\_

Related Medication \_\_\_\_\_

Dates of Therapy \_\_\_\_\_

(\*If more space needed write on the back\*)

2. Did you ever require hospitalization for a psychological reason? Y/N

If yes:

Reason \_\_\_\_\_

Hospital \_\_\_\_\_

Dates of stay \_\_\_\_\_

Diagnosis \_\_\_\_\_

3. Have you, your partner/spouse or children ever previously seen a therapist? If so, at what age(s)? Whom did you or they see and for what reason? About how many meetings did you have? Was the experience helpful?

4. Have you ever been molested or physically, emotionally or sexually traumatized? If so, please provide any details you believe would be relevant to my understanding of your life?

5. Have you experienced any significant losses in your lifetime? Please explain.

Please list any significant life traumas:

Please write quantity for the following:

Abortions \_\_\_\_\_

Miscarriages \_\_\_\_\_

Stillbirths \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Developmental History**

(If adopted, please answer to the best of your knowledge.)

Were there any illnesses/complications during your mother's pregnancy?

# of pregnancies your mother had: \_\_\_\_\_ Miscarriages: \_\_\_\_\_

Please explain circumstance(s):

How would you compare yourself with your siblings, if you had any?

During your infant/toddler years, did either parent stay home full or part time?  
If so, please elaborate on the circumstances.

At what age did you go to daycare or preschool? What type of situation was this (e.g., home, day care center, etc.)? How many hours per week?

As a toddler or young child did you have any history of emotional or behavioral difficulties, such as (please circle):  
head banging, breath holding, day soiling, excessive temper, tantrums, irritability, obsessive thoughts, a compulsive need to count things or touch them, overly aggressive behavior, or difficulty controlling your impulses

If so, approximately when did this start?

Did you ever: \_\_\_\_\_ Age Began \_\_\_\_\_ Still Occurring \_\_\_\_\_  
Hurt yourself in any way (with eating too

much or too little, cutting yourself, etc.): \_\_\_\_\_

Have excessive sleep problems \_\_\_\_\_

Nightmares or night terrors? \_\_\_\_\_

Have excessive bedwetting difficulties? \_\_\_\_\_

Exhibit excessive fears? \_\_\_\_\_

Exhibit excessive fantasizing? \_\_\_\_\_

Intentionally hurt others? \_\_\_\_\_

Have problems going to school? \_\_\_\_\_

Exhibit difficulty paying attention,  
concentrating or with distractibility? \_\_\_\_\_

Exhibit frequent mood changes? \_\_\_\_\_

Exhibit motivational problems? \_\_\_\_\_

Have difficulty with substance abuse?  
(Please explain below) \_\_\_\_\_

Other (please explain): \_\_\_\_\_

**Education/Work History**

Last year of education completed: \_\_\_\_\_

Have you ever interrupted your educational goals due to emotional/personal problems? Y N If so, please explain:

Any skipped grades? \_\_\_\_\_ Which grade(s)? \_\_\_\_\_  
Any repeated grades? \_\_\_\_\_ Which grade(s)? \_\_\_\_\_

Favorite subjects: \_\_\_\_\_

Difficult subjects: \_\_\_\_\_

Did you participate in special education or learning resource classes? If so, please describe the type of services provided:

College(s)/Graduate School Programs and Degrees Held: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you excel at any sports, have special creative music, dance or art talent, etc?

Have you changed your place of employment in the last five years? Y N If so, please explain:

List any significant and positive life influences:

Who are you most like, in your family?

With whom do you share secrets, worries, or feelings?

How do you best motivate yourself?

What are your hobbies and interests?