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Adult Questionnaire

Name: _____ Date: _____

Please describe the reason for today's visit (include current concerns and stressors).

Symptom Checklist:

Please circle all items below that you've experienced in a significant way in the last month.

nightmares	feeling numb	anxiety
anger outbursts	depressed mood	irritability
compulsive overeating	fatigue	boredom
difficulty concentrating	feeling overwhelmed	guilt/regret
tearfulness	irrational thoughts	apathy
loss of appetite	mood swings	restlessness
confusion	agitation	insomnia
hopelessness	social isolation	self-harm
emptiness	reckless behaviors	despair
hallucinations	impulsivity	loneliness
family conflict	constant worrying	obsessive thoughts
muscle aches/tension	headaches	pessimism
loss of pleasure	indecisiveness	suicidal thoughts
overuse of alcohol	sexual difficulties	aggression towards others
procrastination	racing thoughts	self-consciousness



Medical History:

Please list prescribed medications you're currently taking along with the condition being treated.

Are you receiving mental health treatment or counseling at the present time? Yes No

If so, please provide that professional's contact information.

Name _____ Phone Number: _____

Would you like us to contact this professional to coordinate your treatment? Yes No

Have you experienced any of the following? Check any that apply:

- | | Date(s) |
|--|----------------|
| <input type="checkbox"/> Allergies | _____ |
| <input type="checkbox"/> Asthma | _____ |
| <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Encephalitis | _____ |
| <input type="checkbox"/> Fainting Spells/Blackouts | _____ |
| <input type="checkbox"/> Head Injuries | _____ |
| <input type="checkbox"/> Meningitis | _____ |
| <input type="checkbox"/> Problem with Hearing | _____ |
| <input type="checkbox"/> Problems with Vision | _____ |
| <input type="checkbox"/> Seizures | _____ |
| <input type="checkbox"/> Tics | _____ |
| <input type="checkbox"/> Other (please explain) | _____ |
| _____ | _____ |

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Mental Health History:

Have you been treated for a mental health condition in the past? Yes No

Condition / Diagnosis: _____

Past Psychiatric Medication (please list names of medication and ages when used):

Type of Therapy (i.e. CBT, DBT, psychoanalytic, unknown): _____

Have you been in couples or family therapy before? Yes No

Have you made any suicide attempts in the past? Yes No

Have you been hospitalized for mental health reasons in the past? Yes No

Reason: _____

Dates: _____

Name of Hospital: _____

Substance Use History: (circle one)

How often do you drink alcohol? None monthly weekly daily

On the days that you drink, how many drinks do you usually have?

Less than 2 2-3 4-5 5 or more

Do you consider your alcohol or drug use problematic? Yes No

Do others consider it a problem? Yes No

Have you ever been in treatment for alcohol or drug abuse? Yes No

Have family or friends ever thought it was a problem for you in the past? Yes No

Employment:

Are you currently employed? Yes No

Occupation: _____ How long have you been at this job? _____

If you're not employed, are you... (circle all that apply) a student retired seeking work

stay-at-home parent volunteering caring for sick or elderly other: _____

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Are current problems or symptoms affecting your job? Yes No

If yes, in what ways? _____

Education: (circle one)

What is the highest degree you've completed to date?

Some high school high school degree some college college degree technical training
graduate or professional school other: _____

Have you ever been diagnosed with an attention disorder (e.g. ADD/ADHD)? Yes No

Have you ever been diagnosed with a learning disability? Yes No

If you are currently a student, what school do you attend? _____

Program of Study: _____

Estimated GPA: _____ Estimated Graduation Date: _____

If you are receiving academic accommodations, please describe: _____

Are current problems or symptoms affecting your academic performance? Yes No

If yes, in what ways? _____

Family Background:

Where were you born and raised? _____

Marital status (circle one): Single Living with Partner Married Separated

Divorced Remarried Widowed Other: _____

How many years have you been married or living with your current partner? _____

What is your partner's current place of employment? _____

If you've been married before, list previous spouses, # of years married, and year of divorce.

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Do you have children? Yes No If yes, how many? _____

Please list the names and ages of your children: _____

Are there special custody arrangements with your children? Yes No

If yes, please explain: _____

Do any of your children have special needs? Yes No

If yes, please describe. _____

Please list those currently living in your household.

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has there been any violence in your household or in your close relationships? Yes No

Is anyone in your household or close relationships abusing alcohol or drugs? Yes No

Is anyone close to you suffering from emotional problems? Yes No

If you responded yes to any of the three questions above, please describe:

Family History:

During your childhood, did anyone in your family suffer from mental health or substance abuse problems? Yes No

Did you experience severe stressors or traumatic events in your childhood (e.g., witnessing or experiencing abuse)? Yes No

If you responded yes to any of the questions above, please describe:

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Do any of your relatives have any of the following psychological/psychiatric conditions?
Check any that apply:

- | | Relative (i.e., mother, sibling, uncle, etc...) |
|---|--|
| <input type="checkbox"/> Anxiety or Frequent Worrying | _____ |
| <input type="checkbox"/> ADD/ADHD | _____ |
| <input type="checkbox"/> Attempted/Completed Suicide | _____ |
| <input type="checkbox"/> Autism/Asperger's | _____ |
| <input type="checkbox"/> Conduct Problems | _____ |
| <input type="checkbox"/> Depression | _____ |
| <input type="checkbox"/> Learning Disability | _____ |
| <input type="checkbox"/> Manic Depression | _____ |
| <input type="checkbox"/> Substance Abuse | _____ |

Share any comments you would like about your cultural, religious and ethnic background here:

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