# HENRIKE B. KROEMER, PH.D.
# ADULT HISTORY FORM

Date completed _____

## INTRODUCTORY INFORMATION

Name _____Date of Birth _____
(last) (first) (middle)

Address _____

_____

Telephone: home _____ work _____ cell _____

_

Email address _____ Soc Sec # _____

Gender _____ Marital Status _____ Age _____

How do you describe your ethnic/cultural heritage? _____
_____

Religion/religious upbringing? _____
_____

Do you regularly attend religious services? _____

Who is to be notified in the case of an emergency? _____

Relationship to you? _____ telephone number(s) _____

Other contact information for emergency contact person _____

What kinds of concerns have led to you to seek assistance at this time? Please also list any major stressors that have occurred in the last 12 months. _____

_____

_____

_____

_____

_____

Who , if anyone, recommended that you contact my office? _____

_____

## YOUR FAMILY (please complete chart)

| | Name | Age | Full, half, step, adopted | Marital status | Where living? | Occupation | (Leave blank) |
|---|---|---|---|---|---|---|---|
| Spouse | | | | | | | |
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| Children | | | | | | | |
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| Father | | | | | | | |
| Mother | | | | | | | |
| Brother(s) | | | | | | | |
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| Sister(s) | | | | | | | |
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Who currently lives in your household? _____

_____

_____

Please give a description of your father's personality and your relationship with him past/present:

_____

_____

_____

Please give a description of your mother's personality and your relationship with her past/present:

_____

_____

_____

If you have/had step-parents, please give a description of your relationship with them past/present:

_____

_____

_____

If you have/had step-siblings, please give a description of your relationship with them past/present:

_____

_____

_____

Is there additional information that is important for me to know about any family members?

_____

_____

_____

Please describe the home atmosphere in *which you grew up.* What was the discipline style, religious training, communication style, etc? Where there losses or separations? Do you recall abuse of any kind? Where family members troubled by addiction or other problems?

_____

_____

_____

_____

_____

_____

Please describe the home atmosphere in *which you currently reside.* What is the discipline style, religious training, communication style, etc? Have there been/are there losses or separations? Is there abuse of any kind? Are any family members troubled by addiction or other problem?

_____

_____

_____

_____

_____

_____

Are there changes you would like to make in your *home or family life* currently?

_____

_____

_____

_____

**DEVELOPMENTAL HISTORY**

City and state of your birth _____

Where you delivered at full-term? _____ If not, what was the gestational age? _____

To your knowledge, did your mother consume alcohol, other drugs, or smoke during pregnancy?

_____

_____

Please check any of the following that applied to you during your childhood:

□ eating problems □ weight problems □ fears □ excessive shyness □ night terrors
□ bed wetting □ sleepwalking □ speech problems □ learning disabilities □ ADD
□ ADD with hyperactivity □ drug or alcohol use □ abuse or neglect □ delinquency
□ running away □ few childhood friends □ cruelty to animals □ frequent illness
□ excessive anxiety or repetitive behaviors □ suicidal thought or behaviors □ autism
□ was teased a lot (if so, about_____) □ spankings/physical discipline
□ other_____

_____

_____

Was your health during childhood and adolescence generally good? _____
If not, please elaborate:

_____

_____

_____

Were you on any of the following medications as a child?

☐ ADD/ADHD meds (if so, which? _____)
☐Dexedrine
☐antidepressant meds (if so, which? _____)
☐tranquilizers or mood stabilizing meds
☐anti-anxiety meds
☐sleeping aids
☐antipsychotics/neuroleptics
☐others _____

_____

**EDUCATIONAL/VOCATIONAL/LEGAL HISTORY**

Where did you attend grade school? _____

Where did you attend middle school? _____

Where did you attend high school? _____

Highest grade completed? _____ Attended college/graduated? _____

Graduate Education? _____

In general, how were/are your relationships with teachers? _____

How did you do in school? _____

_____

What did you like (and not like) about school? _____

_____

_____

Were you ever suspended or expelled? _____ if so, why? _____

_____

Have you ever served in the military? _____
If so, please describe your experience (rank? overseas service? combat service?etc)
_____

_____

_____

_____

If no longer in the service, what were the circumstances of your discharge?
_____

_____

Have you had difficulties related to your military service?
_____

_____

_____

Are you currently facing legal difficulties or charges (traffic, civil, criminal)?
____yes ____no

If yes, please describe and indicate the court and hearing/trial dates and charges:
_____

_____

_____

_____

Are you presently on probation or parole? ____yes ____no

If yes, please describe:
_____

_____

_____

In the past, have you had
Traffic violations? ____ yes ___ no DWI, DUI, etc.? ___ yes ___ no
Criminal involvement? ____yes ____no Civil involvement?____yes ____no

If you responded "yes" to any of the above, please complete the following information.

| Charges | Date | Where (city) | Outcome |
|---|---|---|---|
| | | | |
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Are you here under the advice of an attorney? ___yes ____no

If yes, please give his/her name, contact information, and the nature of your legal representation:
_____

_____

_____

What is your current profession? _____

Please briefly describe your work history: _____

_____

_____

_____

_____

Are you content with your occupation and work life? If not, please describe:

_____

_____

_____

_____

**CURRENT SOCIAL/MARITAL HISTORY**

Are you presently married? _____ Date of marriage_____

Are you currently in another kind of long-term relationship? _____

If so, when did this relationship begin? _____

How many children are there from this marriage/relationship? _____

How many children are there from past marriages/relationships? _____

Are there any problems with your current marriage/relationship? _____

If so, please describe: _____

_____

_____

_____

_____

_____

If you have been married previously, please describe including dates, reasons for ending, etc:

_____

_____

_____

_____

_____

_____

Describe how you spend your free time, including activities, hobbies, sports, special interests

_____

_____

_____

Are there aspects of your social life that you would like to change? _____

If so, describe: _____

_____

How do you generally get along with, or relate to, other people: (check all that apply)

____ Affectionate ____ Aggressive ____ Avoidant ____ Fight/argue often ____ Follower
____ Friendly ____ Leader ____ Outgoing ____ Shy/withdrawn ____ Submissive
____Mistrusting ____Dependent _____Independent ____Avoidant
____ Other (specify):

_____

_____

_____

How do you describe your sexual orientation? _____

How do you describe your gender orientation? _____

Sexual dysfunctions? ____yes ____no
If yes, describe:

_____

_____

**HEALTH AND MEDICAL HISTORY**

Who is your primary care physician? _____

Physician's Address _____

Date of your last physical exam _____ Were your referred here as a result? _____

Please check any symptoms that are troubling you currently:

□ Weight gain
□ Weight loss
□ No appetite
□ Increased appetite
□ Digestive problems
□ Errors in judgement
□ Difficulty concentrating
□ Memory problems
□ Insomnia
□ Excessive sleepiness
□ Restless sleep or restless legs
□ Numbness or tingling
□ Excessive worry
□ Compulsive behaviors
□ Sleepwalking
□ Nightmares or night terrors
□ Early awakening
□ Feeling tense
□ Unable to relax
□ Heart palpitations
□ Chest pain
□ Feeling panic
□ Afraid to leave home
□ Tremors
□ Headache
□ Back pain
□ Chronic pain
□ Other pain
□ Blurry vision
□ Feeling sickly
□ Menstrual problems
□ Menopausal problems
□ Mid-life concerns
□ Aging concerns
□ Concerns about your appearance
□ Fainting episodes
□ Feeling dizzy
□ Sexual problems
□ Sexual infidelity
□ Irritability
□ Cyber-addiction
□ Irrational fears
□ Self-injurious behaviors
□ Substance use or dependence
□ Recurring thoughts
□ Recurring dreams
□ Sleepwalking
□ Unusual eating patterns
□ Avoidance of eating
□ Social Avoidance
□ Avoidance of time alone
□ Withdrawal symptoms
□ Reckless behaviors
□ Unexplained medical symptoms
□ Feeling tense
□ Mood shifts
□ Gambling
□ Digestive problems
□ Suicidal behaviors
□ Suicidal ideas

Briefly discuss how the above symptoms impair your ability to function effectively:

_____

_____

_____

_____

_____

_____

Describe any other health problems, conditions, medication problems, intolerances or allergies that currently concern you:

_____

_____

_____

Please list any surgeries, hospitalizations, major illnesses, or physical limitations that you have had:

_____

_____

_____

Describe any illnesses that run in your family, and identify the relationship of the family member:

_____

_____

_____

Have you participated in mental health or substance abuse treatment in the past? Please describe your experience, including any residential treatment. Please indicate dates, duration, and agency or treating therapist:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you *currently* drink alcohol? _____

If so, how many drinks (1 glass wine, I shot liquor, 1 beer) do you typically have during the weekdays? _____ On the weekend? _____

Regardless of how much you drink, have you ever thought that you should cut back on your drinking? _____ Have others suggested you do? _____

if so, has this annoyed you when they do? _____

Have you ever had a morning drink (an "eye opener" ) to get you through the day? _____

Please describe any aspects of your use of alcohol that are of concern to you:

_____

_____

_____

Do you smoke cigarettes? _____

If so, how many packs per day? _____ For how long? _____

Is it your goal to cut back or stop smoking? _____

Do you *currently* use recreational or "street" drugs? _____
Have you used recreational or "street" drugs *in the past*? _____
If so, please describe:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please use the chart below to indicate any medications you take or have taken (and their dose, if known) and who prescribes or prescribed this medication:

| MEDICATION | DOSAGE | WHEN USED | PURPOSE | PHYSICIAN | (leave blank) |
|---|---|---|---|---|---|
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What are your goals for therapy?

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*Thank you very much for completing this questionnaire*.