Adult Mental Health Questionnaire

PATIENT INFORMATION **Allergies:** _____ **Weight:** _____ **Date:** _____

Patient Information	*First Name*		*Email Address:*	
	Middle Name		*Phone Number:*	
	Last Name			
	Street Address			*Apt*
	City		*State*	
	Zip Code	*Date of Birth*	*Age*	*Height*

REFERRED BY

_____

CURRENT/ON-GOING PROBLEMS

Why are you coming in for help at this particular time? _____

_____

_____

_____

_____

Please List all current and ongoing problems and diagnoses in order of priority:

Describe Problem	*Mild*	*Moderate*	*Severe*	*Prior Treatment/Approach*	*Excellent*	*Good*	*Fair*
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐

When did you first notice problems? _____

_____

_____

_____

_____

FOOD HISTORY

Typical Breakfast	
Typical Lunch	
Typical Dinner	
Snacks	
Favorite Foods	
Food Intolerances	

GENERAL QUESTIONS

What do you do for exercise?

Please describe: _____

Please describe your current job or class schedule?

Please describe: _____

What kind of activities and hobbies do you enjoy?

Please describe: _____

Do you do well in sports and have good gross motor skills?

Please describe: _____

Do you have good handwriting and fine motor skills?

Please describe: _____

Have you experienced any major life changes or losses that may have impacted your health? ☐ *Yes* ☐ *No*

If yes please describe: _____

Have you ever sought counseling for yourself? ☐ *Yes* ☐ *No*

If yes please describe: _____

Have you ever been abused or been a victim of crime? ☐ *Yes* ☐ *No*

If yes please describe: _____

Do you feel stressed? ☐ *Yes* ☐ *No*

If yes please describe: _____

Have you previously used illicit drugs? ☐ *Yes* ☐ *No*

If yes please describe: _____

Do you currently use illicit drugs?	☐ *Yes* ☐ *No*
Do you get along well with friends and family members?	☐ *Yes* ☐ *No*
*If **no** please describe:* _____	
Do you sleep well?	☐ *Yes* ☐ *No*
*If **no** please describe:* _____	
How many hours do you sleep per night?	
Do you snore or have sleep apnea?	☐ *Yes* ☐ *No*
How much screen time (computer, TV, etc.) do you have per day?	
How much time do you spend on video games per day?	

SCHOOL HISTORY

What grade in school are you currently in or what was the last grade you finished and when?	
Have you ever been in special education?	☐ *Yes* ☐ *No*
If yes please describe: _____	
Have you ever received special help in school or tutoring?	☐ *Yes* ☐ *No*
If yes please describe: _____	
Have you ever been considered a behavior problem at school or at home?	☐ *Yes* ☐ *No*
If yes please describe: _____	
Have you always been able to complete your homework on time?	☐ *Yes* ☐ *No*
If no please describe: _____	
Have you ever been evaluated for learning disabilities?	☐ *Yes* ☐ *No*
If yes please describe: _____	

What kind of grades did you get in school?
_____
_____
_____

Please rate yourself for the following subjects:

	Grade Level	Below Grade Level	Advanced
Reading	☐	☐	☐
Spelling	☐	☐	☐
Writing	☐	☐	☐
Math	☐	☐	☐

ADHD TRAITS EVALUTION

Please check the box if any of these statements describe you:

ADHD Predominantly Inattentive Type (ADHD-I):	
☐	*Fails to give close attention to details or makes careless mistakes*
☐	*Has difficulty sustaining attention*
☐	*Does not appear to listen*
☐	*Struggles to follow through on instructions*
☐	*Has difficulty with organization*
☐	*Avoids of dislikes tasks requiring sustained mental effort*
☐	*Loses things*
☐	*Is easily distracted*
☐	*Is forgetful in daily activities*

ADHD Predominantly Hyperactive-Impulsive Type (ADHD-HI):	
☐	*Fidgets with hands or feet or squirms in chair*
☐	*Has difficulty remaining seated*
☐	*Runs about or climbs excessively*
☐	*Difficulty engaging in activities quietly*
☐	*Acts as if driven by a motor*
☐	*Talks excessively*
☐	*Blurts out answers before questions have been completed*
☐	*Difficulty waiting or taking turns*
☐	*Interrupt or intrudes upon others.*

ADHD Combined Type (ADHD-C):	
☐	*Individual meets both sets of inattention and hyperactive/impulsive criteria*

Adult Mental Health Questionnaire

Under/Over Methylation *Please check any boxes that apply.*

Under Methylation		Over Methylation	
☐	Seasonal Allergies	☐	Chemical and Food Sensitivities
☐	Perfectionism	☐	Under-achiever
☐	Competitiveness	☐	Upper Body Pain
☐	Obsessive-Compulsive Tendencies	☐	Adverse Reaction to SSRI Medication (Prozac, Paxil, Zoloft, St. John's Wort)
☐	Highly Motivated	☐	Dry Eyes
		☐	Self-Injury
		☐	High Artistic/Musical Ability

Left Brian/Right Brain Characteristics *Please check any boxes that apply.*

Right Brain		Left Brain	
☐	Visual	☐	Demonstrates Logical Thinking
☐	Spontaneous	☐	Good with Detail
☐	Likes to be Shown how to do a Task Rather then be Told	☐	Memorizes Easily
☐	Solves Problems by Looking at Similarities and Patterns Rather than Differences	☐	Good at Math
☐	Would Rather Draw than Write	☐	Thinks in Words
☐	Thinks in Pictures	☐	Assimilates Information by Looking at the Pieces before Looking at the Whole
☐	Assimilates Whole Chunks of Information before Breaking Down the Information into Discrete Pieces	☐	Solves problems by Looking at Differences Rather than Similarities

Pyroluria – Please check any boxes that apply.			
☐	Poor Stress Control	☐	Poor Short Term Memory
☐	Fearfulness	☐	Sensitivity to Loud Noises
☐	Sensitivity to Bright Lights	☐	Like Spicy and Salty Foods
☐	Morning Nausea	☐	Pale Skin/Inability to Tan
☐	Tendency to Skip Breakfast	☐	Has Delicate Facial Features
☐	High Irritability and Temper	☐	Extreme Mood Swings
☐	History of Under Achievement	☐	Severe Inner Tension
☐	Little or No Dream Recall	☐	Poor Muscle Development
☐	Auto Immune Disorders	☐	Delayed Growth
☐	Delayed Puberty	☐	Fruity Breath and/or Body Odor
☐	Frequent Infections	☐	Tendency to Stay Up Very Late
☐	Mauve or Dark Colored Urine	☐	History of a Reading Disorder

MEDICAL HISTORY

Blood Type – Please check applicable box.			
☐	A	☐	B
☐	AB	☐	O
☐	Don't Know		

PREVIOUS EVALUATIONS check box if yes and provide year

☐		Full Physical Exam	☐		Psychological Evaluations
☐		WPPSI or WISC-R for Intelligence	☐		Speech and Language Evaluations
☐		Genetic Evaluation	☐		Neurological Evaluations
☐		Gastroenterology Evaluations	☐		Other Injuries
☐		Celiac/Gluten Testing	☐		Auditory Evaluation
☐		Allergy Evaluation	☐		Vision Testing
☐		Nutritional Evaluation	☐		Labs (Please provide copies of results)
☐		X-rays or Scans			

HOSPITALIZATIONS/INJURIES/SURGERIES

Date	Describe

DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide date of onset for any of these conditions if applicable.*

	Date	GASTROINTESTINAL
☐		Irritable Bowel Syndrome
☐		Inflammatory Bowel Disease
☐		Crohn's
☐		Ulcerative Colitis
☐		GERD (reflux)
☐		Celiac Disease
☐		Chronic Diarrhea
☐		Chronic Constipation
		CARIOVASCULAR
☐		Heart Disease
☐		Elevated Cholesterol
☐		Other
		METABOLIC/ENDOCRINE
☐		Type 1 Diabetes
☐		Type 2 Diabetes
☐		Metabolic Syndrome
☐		Hypothyroidism (low thyroid)
☐		Hyperthyroidism (overactive thyroid)
☐		Weight Gain
☐		Weight Loss
☐		Bulimia
☐		Anorexia
☐		Eating Disorder (Non-specific)
☐		Other
		CANCER
☐		

		NEUROLOGIC/MOOD
☐		Depression
☐		Anxiety
☐		Bipolar Disorder
☐		Schizophrenia
☐		Migraines
☐		Seizures

	Date	GENTIAL AND URINARY SYSTEMS
☐		Urinary Tract Infections
☐		Yeast Infections
		MUSCULOSKELETAL/PAIN
☐		Arthritis
☐		Chronic Pain
☐		Other
		INFLAMMATORY/AUTOIMMUNE
☐		Autoimmune Disease
☐		Poor Immune Function
☐		Food Allergies
☐		Environmental Allergies
☐		Multiple Chemical Sensitivities
☐		Latex Allergy
☐		Repeat or Recurrent Strep Throat
☐		Other
		RESPIRATORY DISEASES
☐		Frequent Ear Infections
☐		Frequent Upper Respiratory Infections
☐		Asthma
☐		Chronic Sinusitis
☐		Bronchitis
☐		Sleep Apnea
☐		Other
		SKIN DISEASES
☐		Eczema
☐		Psoriasis
☐		Acne
☐		Other
		NEUROLOGIC/MOOD
☐		Sensory Integrative Disorder
☐		Autism
☐		Mild Cognitive Impairment
☐		Headaches
☐		ADD/ADHD
☐		Other Neurological Problems

FAMILY HISTORY

List all psychological and medical conditions that run in the patient's family:

Family Member	Current Conditions	Past Conditions
Mother		
Father		
Siblings		
Other		

Who do you live with? _____

Is there stress in your current living situation? _____

_____

TRAVEL HISTORY

Have you traveled to foreign countries? ☐ Yes ☐ No **Where?** _____

_____

Any wilderness camping? ☐ Yes ☐ No **Where?** _____

_____

Ever had: ☐ Gastroenteritis ☐ Diarrhea **Describe:** _____

_____

DENTAL HISTORY

Fillings?: ☐ Yes ☐ No **What kind?** _____

Other Dental Problems: ☐ Yes ☐ No **If so, please describe:** _____

_____

Regular Dental Visits?: ☐ Yes ☐ No

MEDICATIONS

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (mo/yr)	Reason for Use

PREVIOUS MEDICATIONS *(Last 10 Years)*

Medication	Dose	Frequency	Start Date (mo/yr)	Reason for Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplement and Brand	Dose	Frequency	Start Date (mo/yr)	Reason for Use

Have medications or supplements ever caused any unusual side effects or problems: ☐ Yes ☐ No **If so, please describe:** _____

_____

Has the patient had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No **If so please describe:** _____

_____

Has the patient had prolonged or regular use of Tylenol? ☐ Yes ☐ No

Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.), Motrin, Aspirin? □ Yes □ No **If so please describe:** _____

_____

Frequent antibiotics > 3 time/year? □ Yes □ No
Long term antibiotics? □ Yes □ No
Use of steroids (prednisone, nasal allergy inhalers) in the past? □ **Yes** □ **No**

GYNECOLOGIC HISTORY *(For Older Females Only)*

Age at first Period: _____ Menses Frequency: _____ Length: _____
Pain: □ Yes □ No Has your period ever skipped?: _____ For how long: _____
Last Menstrual Period: _____ Use contraception? □ Yes □ No If yes, please describe: _____

_____

Are you pregnant? □ Yes □ No
Do you plan on becoming pregnant soon? □ Yes □ No

ANYTHING ELSE

Is there anything else that you would like me to know? _____

_____

_____

_____

_____