BRADLEY D. POWELL, Ph.D.
2400 Broadmoor, Suite C * Bryan, TX 77802

ADULT PSYCHOLOGICAL HISTORY

The purpose of this questionnaire is to obtain a comprehensive picture of your background. By completing these questions as fully and accurately as you can, you will facilitate your therapeutic plan. We request that you answer these questions prior to seeing the doctor so that the actual consulting time can be used to deal with the current problem.

Date: _____

I. Name:_____Age:_____

Please describe the reason for your visit today:

_____

_____

Have you previously consulted anyone about this problem? YES NO

If yes, whom did you consult: _____

II. Please check all of the following that you have experienced recently:

_____ Persistent sadness	_____ Sexual problems	_____ Problems sleeping
_____ Excessive sleep	_____ Dreams/nightmares	_____ Nausea/vomiting
_____ Diarrhea	_____ Constipation	_____ Weight gain/loss
_____ Blurred vision	_____ Change in appetite	_____ Low or High energy
_____ Irritability	_____ Drowsiness	_____ Poor memory
_____ Nervousness	_____ Muscle stiffness	_____ Tremors/jitters
_____ Headaches	_____ Dizziness	_____ Dry mouth
_____ Recurring fears or worries		_____ Periods of rapid heart beat
_____ Suicidal thinking/attempts		

Describe any other recent symptoms:

_____

_____

III. MEDICAL INFORMATION

Date of last physical exam: _____

List surgeries/injuries:_____

_____

_____

How would you rate your overall health?

Poor _____ Fair _____ Good _____ Excellent _____

Have YOU ever had:		Has any of YOUR FAMILY had:	
Y/N	Tumor or cancer	Y/N	Tumor or cancer
Y/N	Heart trouble	Y/N	Heart trouble
Y/N	High blood pressure	Y/N	High blood pressure
Y/N	Thyroid trouble	Y/N	Thyroid trouble
Y/N	Diabetes	Y/N	Diabetes
Y/N	Asthma, Allergies	Y/N	Asthma, Allergies
Y/N	Nervous breakdown	Y/N	Nervous breakdown
Y/N	Arthritis	Y/N	Arthritis
Y/N	Kidney or bladder trouble	Y/N	Kidney or bladder trouble
Y/N	Stroke, fits, seizures	Y/N	Stroke, fits, seizures
Y/N	Tendency to bleed easily	Y/N	Tendency to bleed easily
Y/N	Ulcer	Y/N	Ulcer
Y/N	Jaundice or liver problems	Y/N	Jaundice or liver problems
Y/N	Depression	Y/N	Depression
Y/N	Alcohol, drug problems	Y/N	Alcohol, drug problems

IV. MEDICATIONS:

Please list all medications and dosages that you now take (including over the counter medications):

_____
_____
_____
_____

List any other medications, drugs, or herbs which you use:

_____
_____

How much alcohol do you drink? _____

Have you felt a need to cut down on your drinking? YES NO

WOMEN ONLY Menstrual History:

Do you have regular cycles? YES NO Cycle length:_____

Date of last period: _____ Do you use birth control pills? YES NO