



Individualized therapy for dealing with life challenges

ALL NEW PATIENTS ARE ENCOURAGED TO FILL OUT THIS FORM BEFORE THE FIRST SESSION. YOUR INFORMATION IS CONFIDENTIAL AND WILL BE USED FOR YOUR SOLE BENEFIT. TO INSURE YOUR PRIVACY, PLEASE DOWNLOAD, PRINT, THEN ENTER THE DATA IN YOUR OWN HANDWRITING

COMPRHENSIVE CONFIDENTIAL QUESTIONNAIRE

DATE _____ NAME _____ BIRTHDATE _____

PLACE OF BIRTH _____ WHERE WERE YOU RAISED? _____

CURRENT ADDRESS _____

a.m. PHONE _____ p.m.PHONE _____ CELL _____

Email _____ Race _____

SSN _____ DRIVER'S LICENSE # _____

REFERRED BY _____

NAME, ADDRESS AND PHONE NUMBER OF SOMEONE YOU AUTHORIZE ME TO CALL IN CASE OF EMERGENCY:

WHAT MADE YOU SEEK THERAPY AT THIS TIME?

IF THERAPY IS SUCCESSFUL, HOW WILL YOU AND/OR YOUR LIFE BE DIFFERENT?

WHAT ARE YOUR GOALS FOR THERAPY?

HAVE YOU BEEN IN THERAPY BEFORE? (When? Therapist? Helpful? What was helpful?)

YOUR MARITAL STATUS _____ SPOUSE/PARTNER NAME _____

YOUR CHILDREN'S AGES AND NAMES:

OCCUPATION _____ HOW LONG HAVE YOU HAD THIS JOB? _____

EMPLOYER'S NAME, ADDRESS, PHONE

LIST CAREER OR WORK PROBLEMS _____

HOW WOULD YOUR EMPLOYER AND COLLEAGUES DESCRIBE YOU? _____

IF YOU COULD DO ANYTHING YOU WANTED WHAT WOULD YOU DO? _____

HIGHEST LEVEL OF SCHOOL COMPLETED _____

HAVE YOU BEEN IN THE MILITARY? _____ STATUS _____

WHAT IS THE LONGEST TIME YOU HAVE HELD A JOB? _____ WHEN? _____

PRESENT SALARY _____

CAN YOU MANAGE ON IT? _____ HAVE YOU BEEN IN DEBT? _____

HAVE YOU EVER DECLARED BANKRUPTCY? _____ WHEN? _____

NAME, ADDRESS, PHONE OF NEAREST RELATIVE:

NAME, ADDRESS OF PERSON RESPONSIBLE FOR YOUR FEES _____

DESCRIBE YOUR PERSONALITY AND HOW YOU FEEL ABOUT YOURSELF _____

WHAT WOULD YOU LIKE TO ACCOMPLISH IN THERAPY? _____

HAVE YOU EVER CONSULTED WITH A MENTAL HEALTH PROFESSIONAL? _____

WHO? _____

WHERE? _____ WHEN? _____

WHY? _____

HOW DID IT HELP? _____

MARITAL HISTORY

HOW MANY MARRIAGES HAVE YOU HAD? _____ HOW MANY FOR YOUR SPOUSE/PARTNER? _____

AT WHAT AGES FOR YOU? _____ FOR YOUR SPOUSE/PARTNER? _____

HOW LONG DID THEY LAST FOR YOU? _____ FOR YOUR SPOUSE/PARTNER? _____

HOW LONG DID YOU KNOW YOUR CURRENT SPOUSE/PARTNER/MATE BEFORE YOU MARRIED? _____

HOW LONG ARE YOU MARRIED TO YOUR CURRENT SPOUSE/PARTNER? _____

HOW ARE YOU SUITED TO EACH OTHER? _____

HOW ARE YOU DIFFERENT? _____

WHAT DO YOU LIKE ABOUT YOUR SPOUSE/PARTNER? _____

WHAT DON'T YOU LIKE ABOUT YOUR SPOUSE/PARTNER? _____

CITE PROBLEMS WITH CHILDREN _____

AGE OF FIRST SEXUAL EXPERIENCE _____ WITH WHOM? _____

WHAT WERE YOUR FEELINGS ABOUT IT LATER ON? _____

LIST SEXUAL CONCERNS _____

CHILDHOOD HISTORY

WHO WERE/ARE YOUR PARENTS? (Describe: Names, occupations, personalities- include step parents/grandparents/guardians if significant as caregivers) _____

WHAT WAS THE MOOD OF THE HOUSE? _____

HOW WERE YOU TREATED AS A CHILD? ABUSE? NEGLECT? _____

DID YOU RUN AWAY OR GET PLACED ANYWHERE? (Explain) _____

IMPORTANT EVENTS IN TEENAGE YEARS: _____

HOW MANY CHILDREN IN YOUR FAMILY OF ORIGIN? _____ NAMES & AGES OF YOUR SIBLINGS AND A FEW WORDS TO DESCRIBE EACH SIBLING _____

TO WHICH SIBLING DO YOU FEEL CLOSEST? _____

FURTHEST? _____

WHO, IF ANY, WAS THE FAMILY SCAPEGOAT? _____

WHY? _____

LIST PAST OR CURRENT PROBLEMS WITH PARENTS

FAMILY HISTORY OF: *SERIOUS MEDICAL ISSUES, PSYCHOLOGICAL ISSUES, SUBSTANCE ABUSE AND LEGAL PROBLEMS* _____

DO YOU CONSIDER YOURSELF RELIGIOUS? _____ WHAT FAITH? _____

PHYSICAL HISTORY

PRIMARY CARE PHYSICIAN _____ PHONE NUMBER _____

DATE OF LAST PHYSICAL EXAM _____ REASON _____

RESULTS _____ LIST CHRONIC AILMENTS _____

PSYCHIATRIST _____ PHONE NUMBER _____

HEIGHT _____ WEIGHT _____ ANY RECENT CHANGE IN WEIGHT? _____

HAVE YOU EVER HAD A HEAD INJURY? _____ DESCRIBE _____

DID IT REQUIRE A HOSPITAL? _____ WHEN? _____ DIAGNOSIS _____

LIST DISEASES YOU HAVE HAD AND DATES

LIST YOUR PRESCRIPTION AND OTC MEDICINES –

Current Medications				
Name	Dosage	When Started	Reason	Prescribing Dr.

AGE OF MENSTRUATION _____ MENOPAUSE _____

SURGERIES AND DATES _____

OF PREGNANCIES _____ ABORTIONS _____ EATING DISORDERS _____

LIST STREET DRUGS YOU TAKE OR HAVE USED IN THE PAST _____

HOW OFTEN? _____ WHEN DID YOU START? _____ DO YOU WANT TO

STOP? _____

HOW OFTEN DO YOU DRINK ALOCHOL? _____ HOW MUCH? _____

DO YOU WANT TO STOP? _____ HOW MANY CIGARETTES DO YOU SMOKE PER

DAY? _____ GAMBLING ISSUES? _____

HOW MANY TIMES PER WEEK DO YOU HAVE THE FOLLOWING:

VEGETABLES _____ BREAD/CEREALS _____ MEAT _____ EGGS _____ FISH _____

FRUIT _____ CUPS OF WATER PER DAY _____ DAILY CAFFEINE BEVERAGES _____

DESCRIBE YOUR APPETITE FOR FOOD _____

LIST YOUR FAVORITE FOOD _____

PLEASE LIST AGE OF OCCURRENCE WHERE APPLICABLE:

TEMPER OUTBURSTS _____ BEDWETTING _____ HOW HANDLED _____

FEELINGS OF INFERIORITY _____ FRUSTRATION _____ POLICE ARRESTS
WHY? _____

FIGHTS _____ CUTTING YOURSELF _____

FINGERNAIL BITING _____ SLEEP WALKING _____

INSOMNIA _____ NIGHTMARES _____ DIZZINESS _____ HEADACHES _____

SEEING OR HEARING THINGS THAT AREN'T THERE _____

DEPRESSION _____ HOW WAS IT TREATED? _____

SUICIDAL THOUGHTS OR ACTIONS _____ DATES _____

HOW WAS IT TREATED? _____

UNUSUAL FEARS _____ SHYNESS _____ MOODINESS _____

LONELINESS _____ MARITAL PROBLEMS _____

DESCRIBE CURRENT COMPLAINTS AND EFFORTS TO HELP

HAVE YOU HAD THESE COMPLAINTS BEFORE? _____ WHEN? _____ WHAT
HAPPENED LAST TIME _____

DESCRIBE ANYTHING UNUSUAL GOING ON IN YOUR LIFE NOW

SINCE CHILDHOOD, DESCRIBE ANY PAST EVENTS IN YOUR LIFE WHICH WERE UNUSUAL OR
TRAUMATIC _____

DESCRIBE FOLLOWING IF APPLICABLE:

HAVE YOU EVER OBSERVED VIOLENCE? _____

HAVE YOU EVER BEEN A VICTIM OR PERPETRATOR? _____

HAVE YOU EVER BEEN EXPOSESD TO WEAPONS? _____

HAVE YOU EVER HAD ANY GANG INVOLVEMENT, ANIMAL CRUELTY, FIRE SEETTING?

HOW WOULD THOSE WHO KNOW YOU WELL DESCRIBE YOU? _____

BEST FRIEND'S NAME _____ FOR HOW LONG? _____

DO YOU PREFER TO BE ALONE OR WITH PEOPLE? _____

LIST THE MOST IMPORTANT PEOPLE IN YOUR LIFE PAST AND PRESENT:

NAME _____ RELATIONSHIP _____ AGE _____

NAME _____ RELATIONSHIP _____ AGE _____

NAME _____ RELATIONSHIP _____ AGE _____

WITH WHOM DO YOU LIVE? _____ DESCRIBE YOUR HOME _____

HOBBIES AND INTERESTS _____

WHAT WEAPONS DO YOU OWN? _____ WHY? _____

WHAT IS YOUR FAVORITE ACTIVITY? _____

ON THIS PAGE, PLEASE LIST ANY INFORMATION YOU THINK MAY BE HELPFUL IN OUR WORK TOGETHER.

PLEASE LIST ANY QUESTIONS YOU WOULD LIKE ME TO ANSWER.

DRAW A PICTURE THAT INCLUDES A HOUSE, A TREE AND A PERSON

DESCRIBE YOUR EARLIEST MEMORY

DESCRIBE ANY RECURRENT DREAM