



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:

\_\_\_\_\_

YOUR MARITAL STATUS \_\_\_\_\_ SPOUSE'S NAME \_\_\_\_\_

YOUR CHILDREN'S AGES AND NAMES

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OCCUPATION \_\_\_\_\_ HOW LONG HAVE YOU HAD THIS  
JOB? \_\_\_\_\_

EMPLOYER'S NAME, ADDRESS, PHONE

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LIST CAREER OR WORK

PROBLEMS \_\_\_\_\_

HOW WOULD YOUR EMPLOYER AND COLLEAGUES DESCRIBE YOU? \_\_\_\_\_

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IF YOU COULD DO ANYTHING YOU WANTED WHAT WOULD YOU DO? \_\_\_\_\_

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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

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NAME, ADDRESS OF PERSON RESPONSIBLE FOR YOUR FEES \_\_\_\_\_

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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? \_\_\_\_\_

\_\_\_\_\_

HIGHEST LEVEL OF SCHOOL COMPLETED \_\_\_\_\_

### **MARITAL HISTORY**

HOW MANY MARRIAGES HAVE YOU HAD? \_\_\_\_\_ HOW MANY FOR YOUR SPOUSE? \_\_\_\_\_

AT WHAT AGES FOR YOU? \_\_\_\_\_ FOR YOUR SPOUSE? \_\_\_\_\_

HOW LONG DID THEY LAST FOR YOU? \_\_\_\_\_ FOR YOUR SPOUSE? \_\_\_\_\_

HOW LONG DID YOU KNOW YOUR CURRENT SPOUSE/MATE BEFORE YOU

MARRIED? \_\_\_\_\_

HOW ARE YOU SUITED TO EACH OTHER? \_\_\_\_\_

\_\_\_\_\_

HOW ARE YOU DIFFERENT? \_\_\_\_\_

\_\_\_\_\_

WHAT DO YOU LIKE ABOUT YOUR SPOUSE? \_\_\_\_\_

\_\_\_\_\_

WHAT DON'T YOU LIKE ABOUT YOUR SPOUSE? \_\_\_\_\_

\_\_\_\_\_

CITE PROBLEMS WITH CHILDREN \_\_\_\_\_

\_\_\_\_\_

AGE OF FIRST SEXUAL EXPERIENCE \_\_\_\_\_ WITH WHOM? \_\_\_\_\_

WHAT WERE YOUR FEELINGS ABOUT IT LATER ON? \_\_\_\_\_

\_\_\_\_\_

LIST SEXUAL CONCERNS \_\_\_\_\_

\_\_\_\_\_

HOW MANY CHILDREN IN YOUR FAMILY OF ORIGIN? \_\_\_\_\_ NAMES & AGES OF YOUR

SIBLINGS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

TO WHICH SIBLING DO YOU FEEL CLOSEST? \_\_\_\_\_

FURTHEST? \_\_\_\_\_

BRIEFLY DESCRIBE YOUR MOTHER, FATHER, SISTERS AND \_\_\_\_\_

BROTHERS \_\_\_\_\_

\_\_\_\_\_

WHO, IF ANY, WAS THE FAMILY SCAPEGOAT? \_\_\_\_\_

WHY? \_\_\_\_\_

\_\_\_\_\_

LIST PAST OR CURRENT PROBLEMS WITH PARENTS

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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 – (Medication, when started, dosage strength)

\_\_\_\_\_

\_\_\_\_\_

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? \_\_\_\_\_

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

DESCRIBE ANYTHING UNUSUAL GOING ON IN YOUR LIFE NOW

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DESCRIBE ANY PAST EVENTS IN YOUR LIFE WHICH WERE UNUSUAL\_\_\_\_\_

\_\_\_\_\_

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