

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 _____ e mail _____

SSN _____ 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 _____

OCCUPATION _____ HOW LONG HAVE YOU HAD THIS JOB? _____

EMPLOYER'S NAME, ADDRESS, PHONE _____

HIGHEST LEVEL OF SCHOOL COMPLETED _____

NAME, ADDRESS, PHONE OF NEAREST RELATIVE

NAME, ADDRESS OF PERSON RESPONSIBLE FOR YOUR FEES _____

LIST CAREER OR WORK PROBLEMS _____

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

HAVE YOU BEEN IN THE MILITARY _____ FOR HOW LONG _____

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

HAVE YOU BEEN IN DEBT? _____ ARE YOU CURRENTLY IN DEBT? _____

HAVE YOU EVER DECLARED BANKRUPTCY _____ WHEN _____

DESCRIBE YOUR PERSONALITY AND HOW YOU FEEL ABOUT YOURSELF

WHAT WOULD YOU LIKE TO ACCOMPLISH IN THERAPY _____

HAVE YOU CONSULTED 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 _____

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? _____

WHAT DO YOU LIKE ABOUT YOUR SPOUSE _____

WHAT DON'T YOU LIKE ABOUT YOUR SPOUSE _____

LIST YOUR CHILDREN'S NAMES AND AGES _____

CITE PROBLEMS _____

LIST SEXUAL CONCERNS _____

FAMILY OF ORIGIN HISTORY

HOW MANY CHILDREN IN YOUR FAMILY OF ORIGIN _____ NAMES & AGES OF YOUR SIBLINGS _____

TO WHICH SIB DO YOU FEEL CLOSEST _____ FURTHEST _____

IS YOUR MOTHER STILL ALIVE? _____ FATHER? _____ IF NOT, HOW OLD WERE YOU WHEN THEY PASSED AWAY? _____ HAVE ANY OF YOUR SIBLINGS DIED? _____

BRIEFLY DESCRIBE YOUR MOTHER _____,
FATHER, _____, SISTERS _____, AND
BROTHERS _____LIST PAST OR CURRENT PROBLEMS WITH PARENTS

DO YOU CONSIDER YOURSELF RELIGIOUS _____ WHAT FAITH _____

PHYSICAL HISTORY

DATE OF LAST PHYSICAL EXAM _____ REASON _____

RESULTS _____ LIST CHRONIC AILMENTS _____

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 _____

HAVE YOU EVER BEEN GIVEN MEDICATION FOR PSYCHIATRIC REASONS? _____

BY WHOM? _____ WHEN? _____

WHAT MEDICATION? _____

WHAT MEDICATION ARE YOU STILL TAKING? _____

LIST YOUR OTHER PRESCRIPTION AND OTC MEDICINES _____

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 _____

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 _____

HEART POUNDING/RACING _____ DIFFICULTY TRUSTING _____ TINGLING/NUMBNESS _____

HEADACHES _____ FEARS/PHOBIAS _____ GUILT _____ OBSESSIONS _____

SEEING OR HEARING THINGS THAT AREN'T THERE _____

DEPRESSION _____ HOW WAS IT TREATED? _____

SUICIDAL THOUGHTS OR ACTIONS _____ DATES _____

HOW WAS IT TREATED _____

LOW SELF-ESTEEM _____ SHYNESS _____ MOODINESS _____ ANXIETY _____

LONELINESS _____ MARITAL PROBLEMS _____ FEELINGS OF UNREALITY _____

PHYSICAL ABUSE ISSUES _____ BY WHOM? _____

SEXUAL ABUSE ISSUES _____ BY WHOM? _____

EMOTIONAL ABUSE ISSUES _____ BY WHOM? _____

DESCRIBE CURRENT COMPLAINTS AND EFFORTS TO HELP

HAVE YOU HAD THIS BEFORE? _____ WHEN? _____ WHAT HAPPENED

LAST TIME _____

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

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

HOBBIES AND INTERESTS

DESCRIBE YOUR STRENGTHS/WHAT YOU LIKE ABOUT YOURSELF:

DESCRIBE YOUR WEAKNESSES/ THINGS YOU DON'T LIKE ABOUT YOURSELF:

WHAT WEAPONS DO YOU OWN _____ WHY _____

WHAT IS YOUR FAVORITE ACTIVITY?

PLEASE LIST ANY QUESTIONS YOU WOULD LIKE ME TO ANSWER.