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The purpose of this questionnaire is to obtain a *comprehensive picture of your personal background*. The information you provide will facilitate a more complete evaluation and will also allow more efficient use of your time during your scheduled appointment. Please answer the questions as thoroughly and accurately as possible. *All information is confidential.*

Who Referred you to this office?
❑Friends/Family ❑Pastors ❑Clinic ❑Doctor ❑Court/Lawyer ❑Other________________

Patient Information:
Full Legal Name :____
What would you like to be called? _________________________
Address: Street ____
City ___________________________ ST ______ Zip Code _________________
Age: _________ Date of Birth: _____/____/______
Telephone: Home _______________Work _______________ Cell __________________
Is there a phone number I may use when I need to leave a message regarding appointments, medical information etc?____
In the rare case of an emergency, who should I contact? (not your home number)
Name ________________________________ relationship _______________________
Telephone: Home _______________________ other __________________________
Family Doctor or Primary Care Physician _______________________________________

What type of services are you seeking? Choose any/all that apply
❑Family ❑Couple ❑Adult Individual ❑Child/Adolescent Individual

Financial Responsibility for Payment
Name:_____________________________ DOB:_________________
Address: Street ____
City ___________________________ ST ______ Zip Code _________________
Marital History:
Relationship status: Single Married Divorced Separated Widowed Domestic partnership
If married, length of marriage: _____ Spouses Name:______________________________
Number of previous Marriages: _____ Lengths of prior marriages: ____________________
Reason for divorce: ____

Educational History:
Please circle the last year completed:

Primary	1 2 3 4 5 6 7 8
High School	9 10 11 12
Technical/Vocational	1 2 3 4
College	1 2 3 4

Specify degree ____

Occupational History:
Current employer:____
Length of employment: _________ Type of Work: ______________________
Work Address: ____
Previous Job History:
Employer Type of Job From To Reason for change?
____
____
____

Mental Health History

Briefly describe the nature of the problem for which you are seeking help:
____
____
__

Additional Concerns: Choose any that apply
Interpersonal Issues ❑ N/A ❑Conflict ❑Isolation/avoidance ❑Little to no emotional connection ❑Poor social skills ❑Couple problems ❑Problems with friends ❑Problems at work ❑Overly shy ❑Difficulty Maintaining Relationships

Mood Concerns ❑ N/A ❑Depressed/Sad ❑Hopeless ❑Fearful ❑Anxious ❑Angry ❑Irritable

Sleep ❑N/A ❑Increased Sleep ❑Decreased Sleep ❑Disrupted ❑Nightmares

Eating ❑ N/A ❑Increase ❑Decrease ❑Binging ❑Purging ❑Body Image ❑Other

Anxiety Symptoms ❑N/A ❑Continuous Worry ❑Panic attacks ❑Extreme confusion ❑Phobias ❑Obsessions ❑Compulsions ❑Other

Thought Concerns ❑N/A ❑Poor concentration/attention ❑Denial ❑Self-blame ❑Lack of logic ❑Poor insight ❑Impaired decision making ❑Confusion

Socio-Legal ❑N/A ❑Disregards rules ❑Defiant ❑Stealing ❑Lying ❑Tantrums ❑Arrest/incarceration ❑Initiates Fights

Other symptoms you would like me to know about :

Please list the mental health professionals you have seen in the past (psychiatrists, psychologists, social workers, therapists, counselors): **❑N/A**
Name Locations Dates Reason

____

Please list any past psychiatric hospitalizations/partial programs you have been admitted: ❑**N/A**
Hospital Date Reason for treatment

Please list any psychiatric medications you have taken in the past:❑**N/A**
Medication Date Reason for medication

List all medications you are currently taking, when you take it and for what reason: ❑**N/A**
Medication time of day Reason for medication

Any significant changes in your life, your child's life or your families life within the last 5 years? (deaths, changes of jobs/family roles, schools, marriages/relationships?)

In the space below, please indicate if there are any issues from your childhood, adolescence or any other time in your life which you feel may be of significance (e.g. childhood illness, school problems, parents' divorce, family conflict, history of any type of abuse, etc.)

Have you previously sought therapy? Please list dates of Previous or Concurrent therapy and reason for seeking treatment:

Names of Previous or Concurrent Therapists:

General Medical History

Please list any current or ongoing medical conditions that you are being treated for: ❑**N/A**

List the name, specialty and phone number of any doctors you are currently seeing:❑**N/A**

List any allergies or medication intolerances you have: ❑**N/A**

List any other hospitalizations you have had:❏**N/A**
Reason Date

Do you smoke? ____No ____ Yes, if so, how much per day?_________________________

Please describe your alcohol use:
Type of alcohol Amount How often

Please list any current or past use of other types of drugs: ❏**N/A**
Drug Amount used How often Last used

Have you ever been diagnosed with or treated for a substance use problem?

_____ No _____ Yes If so, where and when?

Family History

Who provided most of your care while growing up? ______________________
How is that person related to you?________________________
Where there significant changes in the relationships of your primary caretakers or family relationships? ❏ Yes ❏ No
If Yes please explain ____
How would you rate your childhood? ❏ Happy ❏ Average ❏ Unhappy

Name Age Psychiatric, substance abuse and medical history
Mother____
Father ____
Siblings____
____
____
Children:

Others: (grandparents, cousins etc.)

Clinician Use Only

Consult/Intake Date:__________________
Fee:_________________
Is Client a dependant minor? ***Attach Parental Consent***