Patient Questionnaire

Section 1: GENERAL

Name:		Date:	
Address:		Home phone:	
Work phone:		Fax:	
Email:		Referred by:	
Age:		Date of birth:	
Marital status:		Education level:	
Occupation:		Names and ages of Children:	
Emergency contact information:			
How client may be contacted by therapist:			

Section 2: FINANCIAL INFORMATION

Annual household income:		Do you rent or own?	☐ Rent ☐ Own
How do intend to pay for treatment?	☐ Cash ☐ Check ☐ Charge ☐ Insurance (if using insurance, fill out adjacent section)	Name of insurance company:	
		Policy Number:	
		Group Number:	
		Telephone Number:	

Section 3: AREAS OF CONCERN

What issues/concerns cause you to seek treatment? Please describe
Do you have any specific goals with regard to your treatment?

Do you have any particular concerns/fears with regard to treatment?

Section 4: PSYCHOLOGICAL HISTORY

An Authorization for Release of Confidential Information will be needed so that any former therapist may be contacted.
When and for how long?
What was the focus of treatment?
Provide the name of the treating therapist(s), address(es), telephone number(s):
Have you ever been hospitalized for mental or emotional problems?
When and for how long?
Why were you hospitalized?
Provide the name of treating therapist, address, telephone number:
Are you currently taking any prescription medications? □ Yes □ No
Prescribed by whom?
How long have you been on the medications?

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Have you ever taken any medication for a mental or emotional condition?
When and for how long?
Have you ever attempted suicide? ☐ Yes ☐ No
When?
Describe the circumstances that led to that attempt.
Are you currently having any suicidal thought? Please describe.
Please describe your childhood.
Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe.
Have you ever been a victim of a violent crime? Please describe.

Section 5: MEDICAL HISTORY

Have you ever been diagnosed with a serious illness? Please describe.
Do you have any medical conditions that may affect your mental health treatment?
Please describe your overall health today.
Are you experiencing any medical/physical symptoms you attribute to mental, emotional, or stress-related condition? Please describe.
Have you ever been in a 12-step program? Please describe.
Do you smoke? □ Yes □ No
How much to you smoke?
For how long have you been a smoker?
Do you drink alcohol? □ Yes □ No
On average, how much alcohol do you consume in a week?
Do you currently use illegal drugs? Please describe.

Section 6: FAMILY OF ORIGIN HISTORY

Mother's name, age, living/deceased, your age at the time of mother's death, description of relationship with mother.
Father's name, age, living/deceased, your age at the time of father's death, description of relationship with father.
Names and ages of siblings.

Section 7: OTHER INFORMATION

Please describe your spiritual identity/orientation.
Please describe your interests/hobbies.
Are you now or have you ever been involved in a lawsuit? Please describe.
Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested.