PATIENT INFORMATION QUESTIONNAIRE

This form is confidential and is designed to help your healthcare professional organize and gather information about you, your history, and the concerns that have led you to seek treatment. Please fill out as much as you are able. If, for any reason, you would rather not answer certain questions, feel free to leave them blank or write in "need to discuss." Thank you.

PERSONAL & CONTACT INFORMATION

NAME:
SSN:
DOB: **GENDER:**
HOME ADDRESS: □ **Okay to receive mail here**
MAILING ADDRESS ***(IF DIFFERENT FROM ABOVE)*****:** □ **Okay to receive mail here**
HOME PHONE: □ **Okay to phone** □ **Okay to leave message**
CELL PHONE: □ **Okay to phone** □ **Okay to leave message**
EMERGENCY CONTACT: □ **Okay to phone** □ **Okay to leave message** **HOME / CELL PHONE:**
PREFERRED EMAIL ADDRESS: ***(PLEASE BE AWARE THAT EMAIL IS NOT A SECURE MEANS OF COMMUNICATION)***
PREFERRED METHOD OF CONTACT: □ **Cell Phone** □ **Home Phone** □ **Email** □ **Mail** □ **Other**
HOW DID YOU HEAR ABOUT THE CLINIC? □ **Medical Referral** □ **Webpage** □ **Psychology Today** □ **Presentation** □ **Friend or Family** □ **Mental Health Referral** □ **Other:**
RELATIONSHIP STATUS:

SEXUAL ORIENTATION:

RACE/ETHNICITY:

LANGUAGE(S) SPOKEN:

RELIGIOUS OR SPIRITUAL AFFILIATION:

ARE YOU CURRENTLY ACTIVE IN YOUR RELIGION?

PRESENTING PROBLEM

PLEASE STATE BRIEFLY WHAT HAS PROMPTED YOU TO SEEK TREATMENT AT THIS TIME?

HOW LONG HAVE YOU BEEN EXPERIENCING THIS PROBLEM(S)?

PLEASE IDENTIFY ANY OF THE BELOW THAT ARE OF CONCERN AT THIS TIME *(PLEASE CHECK ALL THAT APPLY)*:

□ Difficulty Sleeping	□ Relationship Concerns	□ Paranoia
□ Fatigue / low energy	□ Relationship Conflict	□ Loss or Grief
□ Procrastination	□ Infidelity	□ Alcohol or Drug Concerns
□ Burnout	□ Family Problems	□ Injury Recovery / Rehab
□ Motivation	□ Sexual Health Concerns	□ Legal Concerns
□ Academic / Work Concerns	□ Life Transition	□ Compulsive Behavior
□ Assertiveness	□ Infertility Concerns	□ Feelings of detachment / unreality
□ Trouble Concentrating	□ Physical Abuse / Assault	□ Intrusive Upsetting Thoughts
□ Stress Management	□ Sexual Abuse / Assault	□ Intrusive Upsetting Memories
□ Athletic Performance	□ Cultural Concerns	□ Cutting or Self Injury
□ Perfectionism	□ Sexual Orientation	□ Thoughts of Suicide
□ Self-Esteem	□ Gender Identity	□ Medical / Health Concerns
□ Decision Making	□ Personal Growth	□ Mood Swings
□ Learning Problems	□ Clarification of Values	□ Trauma
□ Phobias	□ Diet and Weight Loss	□ Depressed Mood
□ Panic Attacks	□ Disordered Eating	□ Anxiety
□ Nightmares	□ Shyness	□ Episodes of Manic Behavior
□ Anger Issues	□ Loneliness	□ Obsessive Thoughts
□ Feeling Guilty	□ Spiritual or Religious Concerns	□ Racing Thoughts

OUT OF THE ITEMS CHECKED ABOVE, PLEASE LIST YOUR TOP 3 CONCERNS IN ORDER OF IMPORTANCE:

1.

2.

3.

HOW WOULD YOU RATE YOUR CURRENT LEVEL OF DISTRESS REGARDING THE CONCERNS YOU LISTED ABOVE?

MINIMAL **MODERATE** **SEVERE**

1	2	3	4	5	6	7	8	9	10

PLEASE RATE TO WHAT DEGREE YOUR CONCERN(S) AFFECT YOUR DAY-TO-DAY FUNCTIONING:

MINIMAL **MODERATE** **SEVERE**

1	2	3	4	5	6	7	8	9	10

EDUCATION & WORK HISTORY

HIGHEST EDUCATION COMPLETED:

□ Some High School
□ High School Diploma
□ Some College
□ Associate's Degree
□ Bachelor's Degree
□ Some Graduate School
□ Master's Degree
□ Doctoral Degree

WHAT TYPE OF GRADES DID YOU TYPICALLY GET IN SCHOOL?

HAVE YOU BEEN DIAGNOSED WITH A LEARNING DISABILITY? □ **Yes** □ **No**

HAVE YOU EVER SUSPECTED YOU MAY HAVE A LEARNING DISABILITY? □ **Yes** □ **No**

ARE YOU CURRENTLY EMPLOYED? □ **Yes** □ **No**

JOB TITLE / DESCRIPTION:

HOW LONG HAVE YOU BEEN AT YOUR CURRENT POSITION?

APPROXIMATELY HOW MANY JOBS HAVE YOU HAD IN YOUR ADULT LIFE?

FAMILY HISTORY

WHERE WERE YOU BORN?

WERE YOU ADOPTED? □ **Yes** □ **No**

If yes, do you have any knowledge of your birth family?

WHERE DID YOU GROW UP?

HOW MANY TIMES DID YOU MOVE BEFORE YOU WERE 18 YEARS OLD?

DID YOUR PARENTS DIVORCE OR SEPARATE? □ **Yes** □ **No**

If yes, how old were you at the time?

PLEASE LIST THE (FIRST) NAMES AND AGES OF YOUR IMMEDIATE FAMILY MEMBERS *(E.G., PARENTS, SIBLINGS, CHILDREN, SIGNIFICANT CARETAKERS)*:

NAME	RELATIONSHIP	AGE	QUALITY OF RELATIONSHIP
EXAMPLE: *JACOB*	*FATHER*	*74*	*OKAY*

HAS ANYONE IN YOUR IMMEDIATE (PARENTS, SIBLINGS, CHILDREN) OR EXTENDED FAMILY (GRANDPARENTS, COUSINS, ETC.) BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?
OR DO YOU SUSPECT THAT THEY MAY HAVE ANY OF THE FOLLOWING?

□ Disordered Eating

□ Attention problems or ADD/ADHD

□ Addiction issues (alcohol, drugs, gambling)

□ Depression

□ Anxiety, fears, phobias

□ Bipolar Disorder / Manic Depression

□ Schizophrenia

□ Other

If you checked any of the above, please elaborate briefly:

MEDICAL HISTORY

DATE OF LAST PHYSICAL EXAM:

RESULTS OF EXAM:

HAVE YOU EVER BEEN HOSPITALIZED FOR A MEDICAL CONDITION? □ Yes □ No

If yes, please explain:

HAVE YOU EVER SUFFERED A SEVERE HEAD INJURY WITH LOSS OF CONSCIOUSNESS OR CONCUSSION? □ Yes □ No

If yes, please explain:

DO YOU HAVE CHRONIC PAIN? □ Yes □ No

If yes, please explain:

PLEASE LIST PAST AND PRESENT MEDICAL CONDITIONS, PROBLEMS AND/OR DIAGNOSES:

PRIMARY CARE PROVIDER *(NAME, PHONE, ADDRESS)*:

PSYCHIATRIST / PSYCHOLOGIST / PSYCHOTHERAPIST *(NAME, PHONE, ADDRESS)*:

PLEASE LIST ALL MEDICATIONS (AND DOSAGE) YOU ARE CURRENTLY TAKING *(PLEASE INCLUDE PRESCRIPTION MEDICATION, OVER-THE-COUNTER MEDICATION, VITAMINS, ORAL CONTRACEPTIVES AND ALTERNATIVE REMEDIES)*:

PLEASE LIST ALL PSYCHOTROPIC MEDICATIONS YOU HAVE TAKEN IN THE PAST, IF ANY *(PLEASE INCLUDE DOSAGE, DATES OF USE AND ANY SIDE EFFECTS)*:

HISTORY OF:	CHECK ONE:	IF YES, PLEASE EXPLAIN BELOW, INCLUDING DATES IF APPROPRIATE:
Neurologic disorders	□ Yes □ No	
Seizure disorders	□ Yes □ No	
Respiratory disorders	□ Yes □ No	
Cardiovascular disorders	□ Yes □ No	
Hematopoietic-lymphatic disorders	□ Yes □ No	
Eyes/Ears/Nose/Throat Disorders	□ Yes □ No	
Hepatic Disorders	□ Yes □ No	
Dermatologic Disorders	□ Yes □ No	
Musculoskeletal Disorders	□ Yes □ No	
Endocrine-Metabolic Disorders	□ Yes □ No	
Gastrointestinal Disorders	□ Yes □ No	
Renal-Genitourinary Disorders	□ Yes □ No	
Sexual Disorders	□ Yes □ No	
Malignancies	□ Yes □ No	
Allergies or Drug Sensitivities	□ Yes □ No	
Major Surgical Procedures	□ Yes □ No	
Vision problems	□ Yes □ No	
Sexually Transmitted Disease(s) / Infection(s)	□ Yes □ No	
Daytime Sleepiness	□ Yes □ No	
Difficulty Sleeping	□ Yes □ No	
Unusual Diet	□ Yes □ No	
Memory Problems	□ Yes □ No	
Recurring Headaches	□ Yes □ No	
Shortness of Breath	□ Yes □ No	
Serious Head Injury	□ Yes □ No	
Alcohol Abuse	□ Yes □ No	
Other Substance Abuse History	□ Yes □ No	
Other-General	□ Yes □ No	

MEDICAL HISTORY CONTINUED

WERE THERE ANY COMPLICATIONS AT YOUR BIRTH? ***(E.G., PREMATURE BIRTH, MEDICAL PROBLEMS)*** **□ Yes □ No**

If yes, please explain:

DID YOU EXPERIENCE ANY PROBLEMS IN YOUR EARLY DEVELOPMENT ***(E.G., LEARNING TO WALK, TALK, ETC.)*****?**

□ Yes □ No

If yes, please explain:

-FOR FEMALE PATIENTS-

AGE OF FIRST PERIOD:

HOW MANY TOTAL PREGNANCIES HAVE YOU HAD?

HOW MANY TOTAL PREGNANCIES HAVE YOU CARRIED TO TERM?

WHICH BEST DESCRIBES YOUR MENSTRUAL CYCLE NOW?

□ Regular
□ Irregular
□ Pre-menopausal
□ Menopausal
□ Post-Menopausal

RELATIONSHIP HISTORY

AGE AT FIRST SIGNIFICANT ROMANTIC RELATIONSHIP:

TOTAL NUMBER OF MARRIAGES / LONG TERM (OVER 1 YEAR) RELATIONSHIPS:

IF YOU ARE MARRIED / PARTNERED, PLEASE BRIEFLY DESCRIBE YOUR RELATIONSHIP:

IF YOU ARE CURRENLTY SINGLE, DIVORCED, SEPARATED OR WIDOWED, PLEASE BRIEFLY DESCRIBE YOUR LAST LONG TERM RELATIONSHIP:

MENTAL HEALTH HISTORY

HAVE YOU EVER SOUGHT MENTAL HEALTH TREATMENT? □ Yes □ No

If yes, please complete the following about your past (or present) treatment experience(s)

PROVIDER NAME:	PROVIDER CONTACT INFO:	APPROXIMATE DATES:	PROBLEM(S) ADDRESSED?	WAS TREATMENT HELPFUL?

HAVE YOU EVER BEEN HOSPITALIZED FOR A PSYCHIATRIC CONDITION? □ Yes □ No

If yes, please describe the circumstances of your hospitalization (how long, name of facility, dates):

HAVE YOU EVER BEEN ADMITTED TO RESIDENTIAL OR INTENSIVE OUTPATIENT TREATMENT? □ Yes □ No

If yes, please describe the circumstances of your treatment (how long, name of facility, dates):

DO YOU USE TOBACCO? □ Yes □ No

If yes, please indicate the amount and frequency:

HOW MANY BEVERAGES CONTAINING ALCOHOL DO YOU CONSUME IN A TYPICAL WEEK?

HOW MANY BEVERAGES CONTAINING CAFFEINE DO YOU CONSUME IN A TYPICAL DAY?

HAVE YOU USED ANY DRUGS IN THE PAST 30 DAYS THAT WERE NOT PRESCRIBED BY A HEALTHCARE PROFESSIONAL ***(E.G., MARIJUANA, HASH, COCAINE, ADDERALL, DIET PILLS, ECSTASY, VALIUM, LSD, ACID, MUSHROOMS, HEROIN, VICODIN, CODEINE, OR OTHER)*****?** □ Yes □ No

If yes, please describe (including the amount and frequency):

HAS ANYONE EVER SUGGESTED YOU DRINK ALCOHOL OR USE DRUGS TO EXCESS? □ Yes □ No

HAVE YOU EVER BEEN IN TREATMENT FOR SUBSTANCE AND/OR ALCOHOL USE? □ Yes □ No

If yes, please describe the circumstances of your treatment (how long, name of facility, dates):

APPROXIMATELY HOW MANY HOURS PER DAY DO YOU SPEND ONLINE?

SOCIAL NETWORKING SITES	
YOUTUBE	
GAMING	
BROWSING	
SHOPPING	
GAMBLING	
PORNOGRAPHY SITES	
OTHER	

DO YOU FEEL YOUR TECHNOLOGY USE IS BALANCED? □ Yes □ No

DO YOU EVER HAVE PROBLEMS CONTROLLING THE AMOUNT OF FOOD YOU EAT? □ Yes □ No

If yes, please describe:

HOW MANY TIMES PER YEAR DO YOU GAMBLE *(ONLINE OR OTHER)*?

HAVE YOU EVER HAD THOUGHTS OF HARMING YOURSELF? □ Yes □ No

If yes, please describe the types of thoughts *(including frequency, intensity and duration)*:

HAVE YOU EVER PURPOSELY INJURED YOURSELF WITHOUT SUICIDAL INTENT *(E.G., CUTTING, HITTING, BURNING)*? □ Yes □ No

If yes, please describe the types of behavior(s) *(including frequency, intensity and duration)*:

IN THE PAST FEW WEEKS, HAVE YOU HAD THOUGHTS OF SUICIDE? □ Yes □ No

If yes, please describe the types of thoughts *(including frequency, intensity and duration)* and whether you have acted on these thoughts:

HAVE YOU SERIOUSLY CONSIDERED SUICIDE IN THE PAST? □ Yes □ No

If yes, please describe:

HAVE YOU EVER ATTEMPTED SUICIDE? □ Yes □ No

If yes, please describe:

HAVE YOU EVER SERIOUSLY CONSIDERED HARMING ANOTHER PERSON? □ Yes □ No

If yes, please describe:

HAVE YOU EVER INTENTIONALLY PHYSICALLY HARMED ANOTHER PERSON? □ Yes □ No

If yes, please describe:

DO YOU CURRENTLY HAVE THOUGHTS OF HARMING ANOTHER PERSON? □ **Yes** □ **No**

If yes, please describe:

HAS ANYONE IN YOUR FAMILY ATTEMPTED OR COMMITTED SUICIDE? □ **Yes** □ **No**

If yes, please describe:

DO YOU CURRENTLY HAVE ACCESS TO ANY WEAPONS, INCLUDING FIREARMS? □ **Yes** □ **No**

If yes, please describe:

LEGAL HISTORY

HAVE YOU EVER BEEN ARRESTED OR CONVICTED OF A CRIME? □ **Yes** □ **No**

If yes, please describe (including when):

ARE YOU PRESENTLY INVOLVED IN A LAWSUIT? □ **Yes** □ **No**

If yes, please describe:

ARE YOU SEEKING TREATMENT DUE TO AN ACCIDENT OR INJURY? □ **Yes** □ **No**

If yes, please describe:

ARE YOU REQUIRED BY A COURT, THE POLICE OR A PROBATION/PAROLE OFFICER TO BE IN TREATMENT?
□ **Yes** □ **No**

If yes, please describe:

REFLECTIONS

WHAT GIVES YOU THE MOST PLEASURE IN YOUR LIFE?

WHAT ARE YOUR MAIN WORRIES OR FEARS?

WHAT ARE YOUR MOST IMPORTANT HOPES AND DREAMS?

OTHER

IS THERE ANYTING ELSE YOU WOULD LIKE YOUR HEALTHCARE PROFESSIONAL TO KNOW?

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