

Instructions

The following Questionnaire will help your therapist more quickly assess your issues and develop a diagnosis and treatment plan. Please bring your completed questionnaire to the first appointment or fax to (919) 845-5431.

Personal Data

Name:		Date:	
Address:		Birth date:	
City:		State:	Zip:
Home Phone:		Work Phone:	
Cell Phone:		Email:	
Marital Status:		Length (if married):	
Name of Partner (if any):			
Employer:			
Emergency Contact Person:		Phone:	
Cancellation Policy: We require a full 48-hours notice for cancellation or rescheduling, or the full fee for the appointment will be charged to your credit card. Please initial cancellation policy: _____			
Name on credit card	Credit card number	Expiration Date	
Please list name, birth date, and sex of any children and other household members (use back of page for additional space):			
Name / Relation	Birth date / Gender	Lives with you	
	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	
Name of Referring Party:		Phone:	
May we contact this person to thank them for referring you?			<input type="checkbox"/> Y <input type="checkbox"/> N

Current Concerns

In your own words, what are the main reasons for which you are seeking help?

Please check all that apply:

<input type="checkbox"/> Sexual concerns	<input type="checkbox"/> Personal / emotional issues	<input type="checkbox"/> Financial issues
<input type="checkbox"/> Relationship / marital	<input type="checkbox"/> Crisis / trauma	<input type="checkbox"/> Stress
<input type="checkbox"/> Job / vocational	<input type="checkbox"/> Health issues	<input type="checkbox"/> Depression / anxiety

Other:

Please list the most stressful current events in your life:

Relationship History

Please list names of partners in previous marriages / long-term partnerships and provide a brief summary of your relationship with each partner:

Medical History

Primary Care Physician (PCP):
List medical problems:
Medications / Dose:

Childhood History

As a child did you have any problems with:	
Learning disabilities <input type="checkbox"/> Y <input type="checkbox"/> N	Depression <input type="checkbox"/> Y <input type="checkbox"/> N
Hyperactivity <input type="checkbox"/> Y <input type="checkbox"/> N	Sexual or physical abuse <input type="checkbox"/> Y <input type="checkbox"/> N
Bed wetting <input type="checkbox"/> Y <input type="checkbox"/> N	Anxiety or other fears <input type="checkbox"/> Y <input type="checkbox"/> N
School fears <input type="checkbox"/> Y <input type="checkbox"/> N	Obsessions or Compulsions <input type="checkbox"/> Y <input type="checkbox"/> N
Significant life trauma(s) including losses, and ages at which they occurred	

Family of Origin History

	Mother	Father
Current age, or if deceased, age and cause of death		
Use three adjectives to describe each parent	1. 2. 3.	1. 2. 3.
Describe your relationship to each parent		
Describe your earliest memory of either parent		
Use three adjectives to describe their marriage	1.	2. 3.
Length of their marriage		
Caption that describes your family of origin		
Number of siblings		
Your place in birth order		
Were you adopted?		
Divorce and remarriage of your parents:		
Your age at divorce		

Reason for divorce	
Relationship to step-parents, if any	
List any major family of origin problems	

Substance Use and Behavior History

Substance / Activity	Amount / frequency
<input type="checkbox"/> Alcohol	
<input type="checkbox"/> Tobacco	
<input type="checkbox"/> Drugs	
<input type="checkbox"/> Marijuana	
<input type="checkbox"/> Medications (not as prescribed)	
<input type="checkbox"/> Reckless behavior	
<input type="checkbox"/> Gambling	
<input type="checkbox"/> Violent history	
<input type="checkbox"/> Convictions for felonies	
Do you or does your spouse, friend, or loved one believe any of these substances or behaviors are a problem in your relationship or work life?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Mental Health History

Is there a self/family history of any of the following problems? (Check all that apply):		
Problem		
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Self	<input type="checkbox"/> Family / Relationship to self:
<input type="checkbox"/> Substance abuse	<input type="checkbox"/> Self	<input type="checkbox"/> Family / Relationship to self:
<input type="checkbox"/> Depression	<input type="checkbox"/> Self	<input type="checkbox"/> Family / Relationship to self:
<input type="checkbox"/> Suicide (or attempts)	<input type="checkbox"/> Self	<input type="checkbox"/> Family / Relationship to self:
<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Self	<input type="checkbox"/> Family / Relationship to self:
<input type="checkbox"/> ADD	<input type="checkbox"/> Self	<input type="checkbox"/> Family / Relationship to self:
<input type="checkbox"/> Bipolar disorder	<input type="checkbox"/> Self	<input type="checkbox"/> Family / Relationship to self:
<input type="checkbox"/> Eating disorders	<input type="checkbox"/> Self	<input type="checkbox"/> Family / Relationship to self:
Mental health hospitalizations of self or family members		
Name	Relationship	Problem
Please state any other personal mental health history: (medications, previous diagnoses, therapy, length of time with therapist, name of therapist)		

Social Contacts

Do you have a friend or family member that you regularly talk to about your life concerns?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you participate in regular social activities?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you participate in a religious or faith-based group?	<input type="checkbox"/> Y <input type="checkbox"/> N

Symptom checklist

Please read the following list carefully and check any conditions that you currently experience.

Circle the number "1" if you are experiencing mild difficulty with an item, and "2" if you are experiencing moderate to severe difficulty.

Leave an item blank if you do not experience this difficulty.

<input type="checkbox"/> Insomnia 1 / 2	<input type="checkbox"/> Sensitivity to bright lights 1 / 2
<input type="checkbox"/> Oversleeping 1 / 2	<input type="checkbox"/> Premenstrual problems 1 / 2
<input type="checkbox"/> Restless sleep or waking early 1 / 2	<input type="checkbox"/> Irregular menstrual cycle 1 / 2
<input type="checkbox"/> Loss of appetite 1 / 2	<input type="checkbox"/> Headaches 1 / 2
<input type="checkbox"/> Increased appetite 1 / 2	<input type="checkbox"/> Dizziness 1 / 2
<input type="checkbox"/> Rapid weight loss or gain 1 / 2	<input type="checkbox"/> Fainting 1 / 2
<input type="checkbox"/> Frequent crying or feeling weepy 1 / 2	<input type="checkbox"/> Rapid heartbeat 1 / 2
<input type="checkbox"/> Frequently sad 1 / 2	<input type="checkbox"/> Frequent indigestion 1 / 2
<input type="checkbox"/> Frequently irritable 1 / 2	<input type="checkbox"/> Overweight 1 / 2
<input type="checkbox"/> Described as angry by loved ones 1 / 2	<input type="checkbox"/> Diarrhea 1 / 2
<input type="checkbox"/> Feeling empty 1 / 2	<input type="checkbox"/> Constipation 1 / 2
<input type="checkbox"/> Feeling abandoned 1 / 2	<input type="checkbox"/> Teeth grinding 1 / 2
<input type="checkbox"/> Tired most of the time 1 / 2	<input type="checkbox"/> Jaw pain 1 / 2
<input type="checkbox"/> Loss of interest socially 1 / 2	<input type="checkbox"/> Throws up food 1 / 2
<input type="checkbox"/> Unable to make decisions 1 / 2	<input type="checkbox"/> Purges with laxatives 1 / 2
<input type="checkbox"/> Worrying much of the time 1 / 2	<input type="checkbox"/> Constrains food intake 1 / 2
<input type="checkbox"/> Described as pessimistic 1 / 2	<input type="checkbox"/> Feels fat 1 / 2
<input type="checkbox"/> Unable to enjoy usual interests 1 / 2	<input type="checkbox"/> Seeing things that are not there 1 / 2
<input type="checkbox"/> Problems with decision making 1 / 2	<input type="checkbox"/> Hearing voices 1 / 2
<input type="checkbox"/> Difficulty concentrating 1 / 2	<input type="checkbox"/> Smell odors that are not present 1 / 2
<input type="checkbox"/> Sometimes panicky 1 / 2	<input type="checkbox"/> Experiences déjà vu 1 / 2
<input type="checkbox"/> Increasingly anxious 1 / 2	<input type="checkbox"/> Loss of time 1 / 2
<input type="checkbox"/> Dislike for weekends/holidays 1 / 2	<input type="checkbox"/> Specific fears (specify) 1 / 2
<input type="checkbox"/> Uncomfortably shy 1 / 2	<input type="checkbox"/> Obsessive or intrusive thoughts 1 / 2
<input type="checkbox"/> Low self-esteem and self-worth 1 / 2	<input type="checkbox"/> Repeating compulsive behaviors (like washing hands) 1 / 2
<input type="checkbox"/> Difficulty making friends 1 / 2	<input type="checkbox"/> Gambles to excess 1 / 2
<input type="checkbox"/> Unable to relax 1 / 2	<input type="checkbox"/> Problems with alcohol 1 / 2
<input type="checkbox"/> Sexual satisfaction low 1 / 2	<input type="checkbox"/> Problems with drugs / medications 1 / 2
<input type="checkbox"/> Loss of interest in sex 1 / 2	<input type="checkbox"/> Problems with reckless behavior 1 / 2
<input type="checkbox"/> Other sexual concerns 1 / 2	<input type="checkbox"/> Violent impulses 1 / 2
<input type="checkbox"/> Pain with sexual intercourse 1 / 2	<input type="checkbox"/> History of violence 1 / 2
<input type="checkbox"/> Problems with pornography 1 / 2	<input type="checkbox"/> Homicidal thoughts 1 / 2
<input type="checkbox"/> Unpleasant dreams (recurring) 1 / 2	<input type="checkbox"/> Suicidal thoughts 1 / 2