

Detailed Questionnaire

Please fill out this questionnaire. The information you provide will be very helpful in our work together. Feel free to attach additional pages, draw pictures, and be creative!

Date _____

1. GENERAL

A. Full Name: _____

Age: _____ Date of Birth: _____ Place of Birth: _____

B. What is your present living situation? _____

C. Names and ages of children

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

D. Who are the most important people in your life?

E. Education/Work

Education Level: _____

Occupation: _____

Employer: _____

What is your present job situation? _____

F. Present interests, hobbies, activities: _____

G. How is most of your free time occupied? _____

2. PROBLEM AREA/GOALS

A. State in your own words the nature and history of your chief complaint:

B. What are your life goals? _____

C. What are your five greatest fears?

1. _____
2. _____
3. _____
4. _____
5. _____

3. FAMILY HISTORY

A. Father's name: _____

Age: _____ Health: _____

If deceased, age and cause of death: _____

Your age at time of father's death: _____

Give a description of your father's personality: _____

B. Mother's name: _____

Age: _____ Health: _____

If deceased, age and cause of death: _____

Your age at time of mother's death: _____

Give a description of your mother's personality: _____

C. Brothers/Sisters (Names, sex, age, and something about each):

D. Give a short history of your closest interpersonal relationships growing up: _____

E. Give details of any forms of abuse you were subject to in childhood (neglect, verbal violence, sexual).

4. PREVIOUS PSYCHIATRIC OR PSYCHOTHERAPIC TREATMENT

A. Have you ever been in psychotherapy before? _____

If yes, when? _____

May I contact your previous therapist(s)? _____

Therapist (1) _____

Address _____

Phone _____

Therapist (2) _____

Address _____

Phone _____

B. Have you ever been hospitalized for an emotional problem? If yes, when, where, and for how long?

C. Have you ever made a suicide attempt? If yes, describe it, when, and the circumstances leading up to the attempt? Do you sometimes think of hurting yourself currently?

D. Have any close relatives been treated for psychiatric problems? If yes, please specify:

E. Has any relative of yours committed suicide? If yes, please specify:

5. MEDICAL HISTORY A. Have you had any of these childhood illnesses?

NO YES DON'T KNOW

Measles _____

Mumps _____

Whooping cough _____

Chicken pox _____

Rheumatic fever _____

Rubella (German measles) _____

B. Have you ever suffered from any of the following illnesses?

NO YES DATE OF ONSET

Cancer	___	___	_____
TB	___	___	_____
Diabetes	___	___	_____
Thyroid trouble	___	___	_____
Kidney trouble	___	___	_____
High blood pressure	___	___	_____
Eye trouble	___	___	_____
Heart trouble	___	___	_____
Neurological disease	___	___	_____
Ulcers	___	___	_____
Head injury	___	___	_____
D.T.'s	___	___	_____
Allergies	___	___	_____

List all allergies: _____

Any other serious illnesses? _____

C. Please list all medical hospitalizations and operations. Give diagnoses and dates:

D. Family History Have any of your blood relatives suffered from any of the illnesses listed above?
If yes, please specify ailment and relative:

Any other serious illness? _____

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E. Drug/Medication History Because many drugs (legal and illegal) have psychological effects, it is important for me to know what drugs you are *currently* taking and/or *have taken in the past*. This information will remain strictly confidential, but it is very important for me to know before you begin therapy so that an accurate assessment of your problem and situation can be made. Please list *all* legally prescribed and illegal drugs ever used (past or present) and describe how often you use them and what effects you seek:

Have any of these drugs been prescribed by a physician? Yes _____ No _____
If so, which drugs and for what reason? _____

Have you had a checkup within the last year? Yes _____ No _____

F. Nutrition

Is your diet unusual in any way? Yes _____ No _____ If so, how?

G. Symptoms Check any of the following symptoms that apply to you at this time. If they occurred in the past, please indicate when

Hair falling out _____	Fainting spells _____
Weight gain _____	Difficulty sleeping _____
Fatigue _____	Drinking too much fluid _____
Constipation _____	Blurred vision _____
Dry skin _____	Deafness _____
Weakness _____	ringing in ears _____
Weight loss _____	Chest pain _____
Tremor _____	Shortness of breath _____
Big appetite _____	Tingling of hands or feet _____
Fast heart beat _____	Ankle swelling _____
Diarrhea _____	Indigestion _____
Poor appetite _____	Nausea or vomiting _____
Headaches _____	Urinary difficulties _____
Dizziness _____	Problems with sexual organs _____
Other _____	

H. Reproductive History, Issues, or Problems: _____

I. Smoking and Drinking

Do you smoke (anything)? _____

What? _____ How much? _____

Frequency? _____

Do you drink alcohol? _____ If yes, how much? _____

What happens to you when you smoke or drink—that is, what does it do for you? _____

J. Physical Activity Do you exercise regularly? Yes _____ No _____

Please describe current/past activity levels and any concerns:

K. Describe the spiritual/religious aspects of your life:

L. What is your ethnicity? How has this affected you? Were you and your family born in the U.S.? If not, why did you come to the U.S.? Were there hardships or separations in the immigration process?
