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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? _____
_____

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

_____
_____
_____
_____
_____
_____

M. Have you ever been on worker's comp or disability? For what, how long, results?

_____

_____

6. SELF-DESCRIPTION

Give a word-picture of yourself. Describe yourself in terms of how you presently feel and see yourself (include both negatives and positives):

_____
_____
_____
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_____
_____

My signature below certifies that I have completed this questionnaire myself or with help from others that I solicited. I understand that this questionnaire supplements previous informed consents.

Signature: _____ Date: _____

(Client)