Adult Initial Questionnaire

Please complete as fully as possible and bring it to your first session. This information will help me get to know you and best serve you.

Today's Date _____/_____/_____

Name: _____
(First) (Last)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Address: _____

_____
(City) (State) (Zip)

Home Phone: ( ) _____ May we leave a message? □ Yes □ No

Cell/Other Phone: ( )_____ May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please note: I use a secure, HIPPA-compliant email server (Hushmail). All emails from me will be encrypted and require a password for you to read.

Emergency Contact Name: _____

Relationship to you? _____

Telephone Number: _____

Marital Status: □ Never Married □ Domestic Partnership/Civil Union □ Married
□ Separated □ Divorced □ Widowed

Please list all the individuals living in your home and ages:
_____
_____
_____
_____
_____
_____

Please list children (adult or youth) who are <u>not</u> living in your home:
_____
_____

EMPLOYMENT INFORMATION

1. Are you currently employed?

□ Full Time □ Part-time □ Unemployed □ On Disability

Employer Name _____

Employer Address _____

Job Title: _____

If Student: □ Full-time □ Part-time School/College: _____

School Address: _____

2. Do you enjoy your work/school? Is there anything stressful about your current work/school?

_____

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Name of Primary Care Physician (PCP): _____

PCP Address: _____

Phone: _____

Fax:_____

□ **I do** / □ **I do not** wish for my PCP to be occasionally informed about my treatment

Signature _____ Date: _____

1. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes

If yes, name of Clinician(s): _____

2. Have you ever been prescribed psychiatric medication? □ Yes □ No

If yes, list here along with dates you were taking the medication:

_____
_____
_____

Please list CURRENT medications, dosages, dates when first prescribed, and prescribing doctor:
_____
_____
_____
_____

3. How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

_____

4. How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

5. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

6. Please list any difficulties you experience with your appetite or eating patterns:

_____

7. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes, for approximately how long? _____

8. Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this? _____

9. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe _____

10. Do you drink alcohol more than once a week? □ No □ Yes

11. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

12. Do you have any allergies? _____

13. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

14. What significant life changes or stressful events have you experienced recently?
_____
_____
_____
_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	_____
Anxiety	yes/no	_____
Depression	yes/no	_____
Domestic Violence	yes/no	_____
Eating Disorders	yes/no	_____
Obesity	yes/no	_____
Obsessive Compulsive Behavior	yes/no	_____
Schizophrenia	yes/no	_____
Suicide Attempts	yes/no	_____
Other: _____	yes/no	_____

ADDITIONAL INFORMATION:

1. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

2. What do you consider to be some of your strengths?

_____
_____
_____
_____

3. What do you consider to be some of your weakness?

_____
_____
_____
_____

4. What would you like to accomplish in therapy?

_____
_____
_____
_____

5. Is there anything else you would like to tell me?

_____
_____
_____
_____