Patient Information Questionnaire

In order to prepare for your first session, we ask that you fill in the following questionnaire. This form is confidential and is designed to help your therapist organize and gather information about you, your history, and the concerns that have led you to seek treatment. Please try to answer every applicable question; enter "N/A" if a question is not applicable.

Identifying Information

Name: _____ _____ _____ _____ _____
First Middle Last Suffix Preferred Name

DOB: _____ SSN: _____ Gender/Pronouns: _____ Race/Ethnicity: _____

Contact Information

Phone: _____
❑ Mobile ❑ Landline

Email: _____
Please note that we cannot guarantee the security of email communication.

Contact Preference (choose all that apply)
❑ Email ❑ Text ❑ Voice

Home Address:

_____
Street

_____ _____ _____
City State Zip

Mailing Address (if different):

_____
Street

_____ _____ _____
City State Zip

Emergency Contact: _____ _____ ( ) -
Name Relationship Phone

Presenting Problem

What has prompted you to seek treatment at this time?

How long have you been experiencing this problem?

What are your goals for treatment?

Presenting Problem (continued)

Please identify any of the below that are of concern at this time (*check all that apply*):

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

Out of the items selected above, please list your top three concerns in order of importance:

1) _____ 2) _____ 3) _____

How would you rate your current level of distress regarding the concerns listed above?

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

1 2 3 4 5 6 7 8 9 10

Minimal Moderate Severe

Please rate to what degree your concerns affect your day-to-day functioning:

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

1 2 3 4 5 6 7 8 9 10

Minimal Moderate Severe

Mental Health History

Please list any prior mental health providers you've worked with, including therapists and psychiatrists:

Approx. Dates	Name	Type of Clinician	What problems did you address? Was treatment helpful?

❑ I have never seen a psychiatrist or therapist before.

Mental Health History (continued)

Have you ever been hospitalized for a psychiatric condition?	❑ Yes ❑ No	*If yes, please describe the circumstances of your hospitalization(s), including how long, facility names, dates:*
Have you ever participated in residential or intensive outpatient treatment?	❑ Yes ❑ No	*If yes, please describe the circumstances of your treatment(s), including how long, facility names, dates:*
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 purposefully injured yourself without suicidal intent? (e.g. cutting, hitting, burning)	❑ Yes ❑ No	*If yes, please describe the types of behaviors (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, when, and please describe:*
Have you ever attempted suicide?	❑ Yes ❑ No	*If yes, when, and please describe:*
Have you ever seriously considered harming another person?	❑ Yes ❑ No	*If yes, when, and please describe:*
Have you ever intentionally physically harmed another person?	❑ Yes ❑ No	*If yes, when, and please describe:*
Do you currently have thoughts of harming another person?	❑ Yes ❑ No	*If yes, please describe:*
Do you currently have access to any weapons, including firearms?	❑ Yes ❑ No	*If yes, please describe:*

Family Mental Health History

Has anyone in your immediate (parents, siblings, children) or extended (grandparents, cousins, etc.) family experienced or been diagnosed with any of the following? OR Do you suspect that they may have any of the following?

- ❑ Depression
- ❑ Bipolar Disorder
- ❑ Anxiety, fears, phobias
- ❑ Attention problems or ADD/ADHD
- ❑ Disordered Eating
- ❑ Addiction issues (alcohol, drugs, gambling)
- ❑ Schizophrenia
- ❑ Attempted or completed suicide
- ❑ Other

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

Medical History

Approximate date of last physical exam:

Past and present medical issues and/or diagnoses:

Have you ever been hospitalized for a medical condition or undergone any surgeries? *(please elaborate)*

Do you have any allergies or drug sensitivities? If yes, please specify the reaction.

Please list <u>all</u> medications (including dose and frequency) you are <u>currently</u> taking *(include prescriptions, over-the-counter medications, vitamins, oral contraceptives, and alternative remedies):*

Please list all <u>past mental health</u> medications you have taken, if any *(include dosage, dates of use, whether they helped, and side effects):*

Common Medical Issues – Do you have a history of:

1	Neurologic disorders	❑ Yes	❑ No
2	Respiratory disorders	❑ Yes	❑ No
3	Cardiovascular disorders	❑ Yes	❑ No
4	Hematopoietic-lymphatic disorders	❑ Yes	❑ No
5	Eyes/Ears/Nose/Throat Disorders	❑ Yes	❑ No
6	Hepatic Disorders	❑ Yes	❑ No
7	Dermatologic Disorders	❑ Yes	❑ No
8	Musculoskeletal Disorders	❑ Yes	❑ No
9	Endocrine-Metabolic Disorders	❑ Yes	❑ No
10	Gastrointestinal Disorders	❑ Yes	❑ No
11	Renal-Genitourinary Disorders	❑ Yes	❑ No
12	Sexual Disorders	❑ Yes	❑ No
13	Malignancies	❑ Yes	❑ No
14	Vision problems	❑ Yes	❑ No
15	Sexually Transmitted Infections/Diseases	❑ Yes	❑ No
16	Recurring Headaches	❑ Yes	❑ No
17	Chronic Pain	❑ Yes	❑ No
18	Other-General	❑ Yes	❑ No

If you answered yes to any of these items, please elaborate in the space below by referencing the number above; include dates if appropriate:

Have you ever suffered a head injury with loss of consciousness, or experienced a seizure?
(please elaborate)

Did you experience any problems in your early development (e.g., learning to walk, talk, etc.) <u>OR</u> were there any complications at your birth? *(please elaborate)*

If applicable:

How many total pregnancies have you had? _____

How many total pregnancies have you carried to term? _____

Social History

Early Life and Family

Were you in foster care and/or adopted? *(Please elaborate)*

Where were you born? _____

Where did you grow up? _____

Have your parents divorced or separated? ❑ Yes ❑ No

If yes, how old were you at the time? _____

Please list your family members' names, ages, and the quality of your relationship with each:

Relation	Name	Age	Relationship Quality

Relationships

What is your sexual orientation? _____

Age at first significant romantic relationship? _____

How many times have you been married? _____

Number of long-term (>1 year) relationships? _____

What is your current relationship status?

❑ single ❑ partnered ❑ married
❑ divorced ❑ separated ❑ widowed

If applicable, please briefly describe your current or most recent relationship:

_____
_____
_____
_____

Language, Culture and Spirituality

What languages do you speak? _____

If you would like, please share any cultural or spiritual background you think would be helpful for us to know:

_____
_____
_____

Education

What is the highest level of education you have completed?

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

What type of grades did you typically get in school?

_____

What type of activities did you engage in at school?

Have you been diagnosed with a learning disability? OR Have you ever suspected that you may have a learning disability? ❑ Yes ❑ No

If yes, please describe:

_____
_____
_____
_____

Employment

Are you currently employed? ❑ Yes ❑ No

Employer: _____

Job Title/Description: _____

Time in current position: _____

Number of jobs you have had in your adult life: _____

Legal

Have you ever been arrested or convicted of a crime? ❑ Yes ❑ No

Are you seeking treatment due to an accident or injury? ❑ Yes ❑ No

Are you presently involved in a lawsuit? ❑ Yes ❑ No

Are you required by a court, the police, or a probation/parole officer to be in treatment? ❑ Yes ❑ No

If you answered yes to any of these items, please elaborate:

_____
_____

Addictive or Potentially Problematic Behavior History

Do you ever have problems controlling the amount of food you eat?	❑ Yes ❑ No	*If yes, please describe:*
Do you use tobacco?	❑ Yes ❑ No	*If yes, please indicate the amount and frequency:*
Do you use alcohol?	❑ Yes ❑ No	*If yes, how many beverages containing alcohol do you consume in a typical week (or, if less frequently, in a typical month or year)?*
Do you use caffeine?	❑ Yes ❑ No	*If yes, how many beverages containing caffeine do you consume in a typical day?*
Do you use cannabis?	❑ Yes ❑ No	*If yes, how often (i.e., per day/week/month)? In what form (i.e., combusted, vaporized, edibles, etc.)? Please elaborate on your reasons for use (i.e., recreational, sleep, anxiety, etc.)?*
Have you used any drugs in the past 30 days that were not prescribed to you by a healthcare professional?	❑ Yes ❑ No	*If yes, please describe:*
Has anyone ever suggested you drink alcohol or use drugs to excess?	❑ Yes ❑ No	*If yes, please elaborate:*
Have you ever been in treatment for substance and/or alcohol use?	❑ Yes ❑ No	*If yes, please describe the circumstances of your treatment(s), including how long, facility names, dates:*
Are there any other behaviors you are having trouble controlling at this time, such as: gambling, internet use, exercise, video games, pornography, etc.?	❑ Yes ❑ No	*If yes, please describe the circumstances of your treatment(s), including how long, facility names, dates:*

Standardized Measures

This section will be very helpful to you and your Therapist in understanding how you are responding to treatment over time.

Over the last two weeks how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things	❑	❑	❑	❑
Feeling down, depressed, or hopeless	❑	❑	❑	❑
Trouble falling or staying asleep, sleeping too much	❑	❑	❑	❑
Feeling tired or having little energy	❑	❑	❑	❑
Poor appetite or overeating	❑	❑	❑	❑
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	❑	❑	❑	❑
Trouble concentrating on things, such as reading the newspaper or watching television	❑	❑	❑	❑
Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	❑	❑	❑	❑
Thoughts that you would be better off dead or of hurting yourself in some way	❑	❑	❑	❑

Standardized Measures (continued)

Over the last two weeks how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge	❑	❑	❑	❑
Not being able to stop or control worrying	❑	❑	❑	❑
Worrying too much about different things	❑	❑	❑	❑
Trouble relaxing	❑	❑	❑	❑
Being so restless that it's hard to sit still	❑	❑	❑	❑
Becoming easily annoyed or irritable	❑	❑	❑	❑
Feeling afraid as if something awful might happen	❑	❑	❑	❑

Please rate your CURRENT (i.e., last two weeks) severity of any difficulty sleeping you may have:	None	Mild	Moderate	Severe	Very Severe
Difficulty falling asleep	❑	❑	❑	❑	❑
Difficulty staying asleep	❑	❑	❑	❑	❑
Problems waking up too early	❑	❑	❑	❑	❑

How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?	Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
	❑	❑	❑	❑	❑
How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?	Not at all Noticeable	A Little	Somewhat	Much	Very Much
	❑	❑	❑	❑	❑
How WORRIED/DISTRESSED are you about your current sleep problem?	Not at all Worried	A Little	Somewhat	Much	Very Much
	❑	❑	❑	❑	❑
To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?	Not at all Interfering	A Little	Somewhat	Much	Very Much
	❑	❑	❑	❑	❑

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?

What are your strengths?

Closing

Thank you for taking the time to complete this questionnaire. Is there anything else you would like your therapist to know?