

In order to provide the best treatment possible, please complete this questionnaire. If you are unsure about any item, or feel uncomfortable answering, please leave that part blank and if you like we can discuss it together in session. The information you provide is protected as confidential.

Client Demographic Information

Full legal name: _____ Date of birth: _____

Home address: _____

Phone:

(home) _____ Is it okay to leave you a message at this number? Yes ___ No ___

(cell) _____ Is it okay to leave you a message at this number? Yes ___ No ___

(work) _____ Is it okay to leave you a message at this number? Yes ___ No ___

Email address: _____ Is your email address confidential? Yes ___ No ___

Please be advised that email is not the most secure form of communication.

Gender: _____

Sexual orientation: _____

Ethnic/cultural background: _____

Native language: _____

Religious/Spiritual orientation: _____

Educational background: _____

Profession and employment status: _____ Relationship status: _____

Partner/Spouse's name: _____ Length of time together: _____

Emergency contact #1 name: _____ phone number: _____

Emergency contact #2 name: _____ phone number: _____

Children (include biological (B.), adopted (A.), foster (F.) & step (S.):

Name	Sex	DOB	Type (B/A/F/S)	Custody (Y/N)

Reason for Seeking Treatment

Please describe your reason(s) for seeking treatment at this time, include date or month or year the problem started: _____

Was there an event which made these issues or problems surface? Yes ___ No ___

If yes, please describe: _____

Please indicate how any of the following symptoms may be bothering you.

	No Problem	Mild Problem	Moderate Problem	Severe Problem
Depression				
Anxiety				
Controlling stress				
Loss of a loved one				
Problems at work or school				
Loneliness				
Problems coping				
Abuse/victimization				
Financial Problems				
Legal Matters				
Marriage/ Relationship issues				
Sexuality				
Sexual issues				
Family conflict				
Eating and or body image issues				
Eliminating drug/alcohol habit				

Other, please specify:

What results do you want from treatment?

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas in your life:

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Relationship						
Family						
Job/School performance						
Friendships						
Physical health						
Financial situation						
Anxiety level						
Mood						
Eating habits						
Sexual functioning						
Sleep habits						
Ability to concentrate						
Ability to control temper						
Spirituality						

What coping strategies have helped?

Not helped? _____

Have you had any mental health treatment in the past? (please include names and dates if possible)

Have you ever been hospitalized due to mental health symptoms? (if yes please include when and for what reasons)

Was there anything during these treatment episodes that was particularly helpful or unhelpful?

Substance Use

Do you currently struggle with substance abuse or dependence? _____

If yes please indicate what type of substance you struggle with _____

How much do you use and how often? _____

Age of first use _____ Date of last use _____

Have you ever experienced withdrawal symptoms, seizures and/or black outs? _____

In the past have you struggled with substance abuse or dependence?

(if yes please explain) _____

Have you ever had treatment for substance use? (If yes please indicate when, where and what type of treatment)

Do you use any substances recreationally (please include alcohol, marijuana, tobacco or other substances)

Do you drink caffeine, if so how much? _____

Medical History

Do you have any allergies to food and/or medications? If yes, please describe: _____

Name and number of Primary Care Physician _____

Please list any prescription medications you currently use including any psychiatric medications:

Does anyone besides your PCP prescribe your medications? If so please indicate name and number

Please list any over-the-counter medications you currently use such as vitamins, sleeping/diet pills, aspirin/pain relievers, etc., include name, dosage, and frequency: _____

How often do you exercise? _____

Any recent weight gain? _____ weight loss? _____

Have you ever struggled with an eating disorder or do you currently struggle with one? _____

Do you engage in any of the following eating disorder behaviors: Purging, bingeing, restricting, over exercising? If yes, how often?

Do you have any current medical diagnoses and if so please list _____
are you being treated for this/them? If yes please share who is providing treatment _____

Do you have any medical symptoms or complaints that you are currently experiencing? Please explain.

Have you ever been hospitalized for a medical issue/ had any significant surgeries or procedures? If yes please state why and when _____

Family History

Has anyone in your family ever experienced any Mental Health struggles? If yes please explain

Has anyone in your family ever experienced any substance abuse / dependence issues? If yes please explain

Has anyone in your family had any significant medical problems

How many siblings do you have? _____ Where are you in the birth order? _____

What is your parent's marital status? _____ if divorced how old were you? _____

How would you describe the nature of your relationship with your family? _____

More about you

What are some of your hobbies/ interests?

What would you consider to be some of your weaknesses?

What would you consider to be some of your strengths?

Is there anything else that you would like me to know about you that you have not already shared?

Thank you for providing me information regarding your health and well-being. I will use this information to build a treatment designed specifically to meet your needs. Please feel free to discuss any aspect of your responses with me. Thanks for your time filling out this form -*Meredith Mirsepassi*