History Questionnaire

The following information is used to best determine a treatment plan. Completing this form as fully and accurately as possible will help facilitate this process. Please write all answers legibly. If you need additional space for any of your answers, please use the space at the end of this form. If you feel uncomfortable revealing some of the requested information, feel free to put an "X" through those sections.

Personal Data

Name:_____ Date:_____

Age:_____ Gender (M/F):_____ SSN:_____

Where were you born?_____

What number child were you? (e.g. 2nd oldest):_____

Where did you spend most of your life?_____

What is your current living environment? (house, apartment):_____

How satisfied are you with your current living environment?_____

Who do you live with? (list people and relationship to you) _____
_____

Family History

Father

Name: _____ Age:_____

If deceased, cause of death: _____ Your age at that time:_____

Father's Occupation: _____

Father's Health: _____

Briefly describe your father's personality and his attitude towards you (past & present):

_____

_____

Mother

Name: _____ Age:_____

If deceased, cause of death: _____ Your age at that time:_____

Mother's Occupation: _____

Mother's Health: _____

Briefly describe your mother's personality and her attitude towards you (past & present):

_____

How would you describe your cultural identity?_____

How would you describe your religious or spiritual identity?_____

Siblings

Provide ages, marital status, and occupations: _____

_____

_____

_____

Briefly describe your relationship with your siblings: _____

_____

_____

Briefly describe your home atmosphere (compatibility with parents, between parents and children, and between siblings): _____

_____

_____

Were you adopted? _____ If yes, at what age? _____ If yes, do you know anything about your biological parents?_____

Are your parents divorced? _____ If yes, what age were you when this occurred? _____
How did you feel about it? _____

If you have a step-parent or step-parents, give your age when parent(s) remarried: _____

If you were not raised by your parents, who was your primary caregiver and between what ages:
_____
_____

Are there any fearful or distressing experiences regarding your family life which stand out in your mind which were not previously mentioned? (briefly describe) _____
_____
_____

Relationship History

What is your current relationship status? (single, co-habiting, engaged, married, separated, divorced, widowed): _____

If in a relationship, how long have you been with your present partner? _____
Partner's first name: _____ Age: _____ Occupation: _____

Briefly characterize your present relationship (e.g. satisfaction, closeness, compatibility):
_____
_____
_____

Briefly describe any previous marriage or significant relationships and what caused the ending of the relationship(s):
_____
_____
_____

If you have children, please list in chronological order the name, age, sex, and level of contact with each child. Also indicate if the children are from your current relationship, previous relationship, or from partner's previous relationship.
_____
_____
_____
_____

Do you have people outside of your biological family and relatives that you feel are close friends or who are "like family" and in whom you can confide?

_____

_____

_____

Educational/Occupational History

Years of education: _____ Degrees (GED, HS Diploma, B.A., etc.) _____

How were your grades in school? _____ In college? _____

Are you currently employed outside the home? _____ Currently in school? _____

Current occupation: _____ Years in this occupation: _____

How satisfied are you with your current occupation or work situation? _____

Briefly describe your work history and reasons for leaving any previous jobs:

_____

_____

_____

Medical History

List any current medical conditions:

_____

_____

_____

List any allergies:

_____

_____

List all medications you are currently taking, including dosages and the dates of initial prescriptions, and the prescribing physician:

Medication Dosage Initial Rx Date Prescribing Physician

_____

_____

_____

_____

List a history of mental health medication you have taken in the past and the dates used:

_____

_____

Are you presently under the care of a physician? _____ If so, list name, address and phone number:

_____

When was your last complete physical exam? _____

Are you aware of any significant information about your birth or development? _____ If yes, please describe: _____

_____

_____

_____

Alcohol/Substance Use History

Do you drink caffeine currently? _____ If yes, describe typical consumption: _____

_____

Do you use tobacco currently? _____ If yes, please describe type and typical amount of use: _____

_____

If no, did you use it in the past? _____

Do you currently drink alcohol? _____ If yes, please describe, type, frequency, and typical amount of consumption: _____

_____

Do you currently use any recreational drugs? _____ If yes, please describe type, frequency, and typical amount of consumption: _____

_____

_____

_____

Have you formerly consumed alcohol or drugs to a greater extent than you do currently? _____

If yes, please describe: _____

_____

_____

Have you ever been in a drug or alcohol treatment program? _____ If yes, please list:

Dates Where Inpatient or Outpatient Outcome

_____

_____

_____

Mental Health History

Have you ever received psychological or psychiatric treatment/counseling before? _____

If yes, please provide the following information:

Dates of care Mental Health provider Purpose Outcome

_____

_____

_____

Have you ever been hospitalized for a psychiatric/emotional reason? _____

If yes, please provide the following information:

Dates Hospital Reason Outcome

_____

_____

_____

Have you ever contemplated or attempted suicide? _____ If yes, please describe:

_____

_____

Have you ever contemplated or inflicted physical violence on another person? _____

If yes, please describe: _____

List any family history of mental health problems. List the relationship (father, sister, aunt, etc.) followed by the problem:

_____

_____

_____

_____

Present Concerns

Please briefly describe your reasons for seeking treatment at this time:

_____

_____

_____

_____

How have these concerns evolved over time?

_____

_____

_____

Please check any of the following feelings or symptoms that apply to you:

__Depressed
__Feel inferior
__Hopelessness
__Crying spells
__Mood swings
__Poor concentration
__Poor memory
__Low energy
__Anxious
__Specific fears
__Panic attacks
__Sleep problems
__Sleeping more than usual
__Relationship problems
__Nightmares
__Feel detached
__Poor appetite
__Food binging
__Food purging
__Angry or irritable
__Guilt
__Difficulty making decisions
__Unable to relax
__Unable to enjoy myself
__Lack of interest in pleasant activities
__Sexual problems
__Memory lapses
__Fearing a loss of control
__Thoughts of harming or killing myself

Please describe how you would like your life to be different when you are done with therapy:

_____

_____

_____

_____

_____

Is there any other information you think I should know prior to our beginning to work together?

_____

_____

_____