Questionnaire

** indicates a required field*

* What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can

* What are your goals for counseling?

* Have you seen a mental health professional before?

Yes

No

* Specify all medications and supplements you are presently taking and for what reason.

* If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.

* Who is your primary care physician? Please include type of MD, name and phone number.

* Do you drink alcohol?

Yes

No

* Do you use recreational drugs?
Yes
No

* Do you have suicidal thoughts?
Yes
No

* Have you ever attempted suicide?
Yes
No

* Do you have thoughts or urges to harm others?
Yes
No

* Have you ever been hospitalized for a psychiatric issue?
Yes
No

* Is there a history of mental illness in your family?
Yes
No

* If you are in a relationship, please describe the nature of the relationship and months or years together.

* Describe your current living situation. Do you live alone, with others. With family, etc...

* What is your level of education? Highest grade/degree and type of degree.

* What is your current occupation? What do you do? How long have you been doing it?

* Please check any of the following you have experienced in the past six months

Increased appetite
Decreased appetite
Trouble concentrating
Difficulty sleeping
Excessive sleep
Low motivation
Isolation from others
Fatigue/low energy
Low self-esteem
Depressed mood
Tearful or crying spells
Anxiety
Fear
Hopelessness
Panic
Other

* Please check any of the following that apply

Headache
High blood pressure
Gastritis or esophagitis
Hormone-related problems
Head injury
Angina or chest pain
Irritable bowel
Chronic pain
Loss of consciousness
Heart attack
Bone or joint problems
Seizures
Kidney-related issues
Chronic fatigue
Dizziness
Faintness
Heart valve problems
Urinary tract problems
Fibromyalgia
Numbness & tingling
Shortness of breath
Diabetes
Hepatitis

Asthma
Arthritis
Thyroid issues
HIV/AIDS
Cancer
Other

What else would you like me to know?