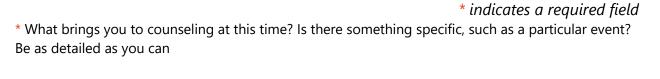


Questionnaire



* 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?