Great Minds
THERAPY

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Patient Questionnaire/Intake

General:

Name _____ Date_____
Address _____
Home phone _____
Work phone _____
E-mail _____
Referred by _____
Age _____
Date of birth _____
Marital status _____
Educational level _____
Occupation _____
Names and ages of children_____
_____
Emergency contact information _____
Explanation of how patient may be contacted by therapist _____

Areas of Concern:

What issues/concerns causes you to seek treatment? Please describe.

_____
_____
_____
_____
_____

Do you have any specific goals with regard to your treatment?

_____
_____

Do you have any particular concerns/fears with regard to treatment?

_____

_____

Psychological History:

Have you ever received mental health treatment before? _____
When and for how long? _____
What was the focus of treatment? _____
Name of treating therapist(s), address(es), telephone number(s)*

_____
Have you ever been subjected to one or more psychological tests? _____
If so, by whom*? _____
Name of person(s) administered psychological tests, address(es), telephone number(s)*

_____

_____

Have you ever been hospitalized for mental or emotional problems? _____

When and for how long? _____
Why were you hospitalized? _____

Name of treating therapist, address, telephone number*

_____

Are you currently taking any prescription medications? Dosage? _____

_____

_____

Prescribed by whom*? _____

How long have you been on the medications? _____
Have you ever taken any medications for a mental or emotional condition?

_____
When and for how long?

_____

Have you ever attempted suicide? _____
When? _____
Describe the circumstances that led to that attempt.

_____

_____

_____

Are you currently having any suicidal thoughts? Please describe
_____
_____
_____

Please describe your childhood _____

Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe.
_____
_____
_____
Have you ever been a victim of a violent crime or other traumatic experience? Please describe
_____
_____

Medical History:

Have you ever been diagnosed with a serious illness? Please describe_____
_____

Have you experienced any bodily or head trauma, fall, or injuries? Please describe the incident(s)
_____
_____
Have you had any surgeries? _____
Do you have any medical conditions that may affect your mental health treatment?
_____
Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe. _____
_____

Please describe your overall health today. _____

Physical activities:

Do you perform any physical activities? Describe (gym, dance class, jogging, etc.)
_____

How many times per week? Duration of each?
_____

Substance Use:

Have you ever been in a 12-step program? Please describe. _____
_____
Do you smoke? _____ How much? _____ For how long? _____
Do you drink alcohol? _____

On average, how much alcohol do you consume in a week? _____
Do you drink coffee? How many cups a day? _____
Do you currently use illegal drugs or marijuana? Please describe your use

_____
Have you *ever* used illegal drugs or marijuana? Please describe

_____

Family of Origin History

Mother's name, age, living/deceased, patient's age at the time of mother's death, description of relationship with mother _____

_____
Father's name, age, living/deceased, patient's age at the time of father's death, description of relationship with father_____

_____
Names and ages of siblings _____

_____

Other Information

Please describe your spiritual identity/orientation _____
Please describe your interests/hobbies _____

_____
Are you now or have you ever been involved in a lawsuit? _____
Please describe. _____

_____
Do you have any close friends? ____Yes _____No If yes, how many? _____
How often do you see your friends? _____
How would you describe your relationships? _____

_____
Do you have other social supports? _____

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested. _____

_____

_____

*The authorization for release of confidential information will be needed in case if any former or current therapists/psychologists/physicians have to be contacted

_____
Great Minds Think Alike,
We Help Yours Heal and Thrive!