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# INTRODUCTION QUESTIONNAIRE

Please answer the questions below and bring this form to your first session.
The information you provide here is protected as confidential information.

Name: _____DATE: _____

Address: _____

City:_____ Zip:_____

Home Phone:_____Work:_____Cell:_____

E-mail: _____Relationship Status:_____

Birth Date :_____ Age: _____Social Security #_____

Employed By:_____Occupation:_____

Employer Address:_____

Education:_____ Major _____Insurance Provider_____

Who Is The Primary on Your Policy?_____SSN#_____DOB_____

Describe Your Reason For Coming In:_____
_____
_____

What Would You Like To Accomplish In Therapy:_____
_____
_____

Have You Been In Therapy Before? If So, How Long?_____

List Any Medications You Are Taking, Dosage, And How Long You've Been Taking Them_____
_____
_____
_____

Who Is Prescribing Your Medication?_____

Who Is Your Primary Care Physician?_____

List Any Major Health Problems You May Have_____
_____
_____

Are You Now or Have You Ever Used Drugs? _____If So, Which Ones_____
_____
How Often Do You Use Them?_____

Do You Drink Alcohol More Than Once Per Week? _____How Often & Amount;_____

Please List Any Health Problems You Are Currently Experiencing:_____
_____
_____
_____

Are You Experiencing Any Sleep Difficulties?
Unable to Fall Asleep _____Stay Asleep _____Difficulty Waking Up_____

Are You Experiencing Eating Difficulties?_____

How Many Times Per Week Do You Generally Exercise? _____What Type_____

What significant life changes or stressful events have you experienced recently?_____
_____
_____

Please Check Any of the Following Problems or Symptoms You are Experiencing:

| | | |
|---|---|---|
| ___Depression | ___Mood Swings | ___Difficulty Concentrating |
| ___Suicidal Thoughts | ___General Anxiety | ___Drinking Problem |
| ___Obsessive Thoughts | ___Panic Attacks | ___Excessive Worry |
| ___Distrust of People | ___Phobias | ___Low Self-Esteem |
| ___Sexual Dysfunction | ___Guilt Feelings | ___Rages |
| ___Problems With Parents | ___Shyness | ___Low Energy |
| ___Problems With Children | ___Destructive Behavior | ___Loneliness |
| ___Compulsive Sexual Behavior | ___Stress Feelings | ___Isolation |
| ___Stress Headaches | ___Marital Conflict | ___Drug Problem |
| ___Difficulty Making Decisions | ___Financial Fears | ___Taken Advantage Of |

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

| | Please Circle | List Family Member |
|---|---|---|
| Alcohol/Substance Abuse | yes/no | |
| Anxiety | yes/no | |
| Depression | yes/no | |
| Domestic Violence | yes/no | |
| Eating Disorders | yes/no | |
| Obesity | yes/no | |
| Obsessive Compulsive Behavior | yes/no | |
| Schizophrenia | yes/no | |
| Suicide Attempts | yes/no | |

Any other information you feel would be helpful to your treatment? _____
_____
_____

Signature_____