Clinical Assessment Questionnaire

GENERAL INFORMATION:

Please provide the following information and answer the questions. Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Name:_____ Today's Date:_____

Your age: _____ Date of Birth (DOB):_____

Address:_____

_____

Spouse or Partner's Name (if applicable): _____

Home phone:_____ May I leave a message? Yes No

Cell phone:_____ May I leave a message? Yes No

Work phone:_____ May I leave a message? Yes No

Email: _____ May I email you? Yes No

(For appointment scheduling purposes only, as email not considered a confidential medium of communication).

Who referred you to this practice? Please provide the organization/person's name & phone.

_____

May I contact the agency/person to thank them for referring you? Yes No Please initial:_____

What is the main reason you're seeking help? (Please include how long you've had these symptoms or problems): _____

_____

_____

_____

What do you want from therapy?_____

_____

_____

Do you currently have any medical problems? _____

_____

_____

Have you ever been treated for any of the following? If so please circle and describe:
Head injury, strokes, seizures, fainting, loss of consciousness, neurologic conditions (Multiple sclerosis, Parkinson's), cancer, headaches, diabetes/kidney, allergies, chronic fatigue, high fevers, surgeries, any other conditions:

_____

_____

_____

Have you previously seen a therapist or psychiatrist? If so, what year? Who did you see and for what reason? About how many meetings did you have? Was the experience helpful or not? How so?

_____

_____

_____

Have you ever been hospitalized for medical or mental illness? If so, list when, where, & reason:

_____

_____

Please list current prescription medications with dosage (psychiatric and general health):

_____

_____

_____

Please list any previous psychiatric medications (with dosage and dates): _____

_____

Do you drink alcohol or use recreational drugs? If so, what kind and how often? _____

_____

_____

Do you or anyone close to you consider your use to be a problem? Yes No

Who is your primary care physician? _____

Who is your psychiatrist (if applicable)? _____

When was your last complete physical exam (month/year)? _____

How many times a week do you exercise? _____ What type and how many minutes? _____

_____

What kinds of foods do you regularly eat? _____

_____

	MOTHER	**FATHER**
Current age, or If deceased date, age, and cause of death		
Country of Origin		
Religious/Spiritual Affiliation (if any)		
Use 3 adjectives or more to describe <u>each</u> parent		
How did you and <u>each</u> parent get along when you were growing up? Give some examples of things that you did together & feelings you had.		
Use 3 adjectives or more to describe your parents' relationship		
How did your parents get along? What were any things they disagreed over?		
Years married or together		
If divorced or not together, your age at divorce		
Reason for divorce/split		
Describe your relationship with step-parents (if any)		
List anyone else who lived with you <u>or</u> regularly cared for you		
Were you adopted? Age?	**If so, please write any relevant information about your biological parents.**	
List any major problems in your family growing up:		

Siblings

Please list all of your brothers and sisters in the order of birth.

First name	Biological (Yes/No)	Current Age	Male/ Female	Married or Partnered? (Yes/No)	Describe your relationship in a few words

Yourself

Where were you born? _____

Where did you live most of your childhood? _____

What was the highest grade of education you completed? _____

When you were a child, did you struggle with any of the following: Age

Learning disabilities Yes No _____
Hyperactivity Yes No _____
Bed wetting Yes No _____
School fears Yes No _____
Teasing/Bullying Yes No _____
Eating disorders Yes No _____
Witnessing violence in the home Yes No _____
Sexual, physical or emotional abuse Yes No _____
If so, at what age and by whom? _____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if any members of your family and extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please circle	List Family Member(s)
Anxiety (general)	Yes No	
Obsessive Compulsive Behavior	Yes No	
Depression	Yes No	
Suicide Attempts	Yes No	
Bipolar/Manic Depressive	Yes No	
Alcoholism	Yes No	
Substance Abuse	Yes No	
Domestic Violence	Yes No	
Eating Disorders	Yes No	
Obesity	Yes No	
Schizophrenia	Yes No	
Counseling or Psychotherapy	Yes No	
Psychiatric Hospitalizations	Yes No	

CURRENT FAMILY, SOCIAL SUPPORTS, OCCUPATION & LIFE INTERESTS/ACTIVITIES

Intimate Relationships & Social Supports

Are you currently married? Yes No How long?_____

Are you currently partnered/in a romantic relationship? Yes No How long? _____

Do you have any concerns about your current marital or romantic relationship that you would like to discuss? If so what are they?

_____

_____

_____

Are you currently separated or divorced? Yes No How long? _____

If you and your former spouse/partner have children together, please describe your current custody & visitation schedule (if any) and the status of your communication: _____

_____

Please describe your social relationships. Do you have friends and/or extended family? Go out for fun? Socialize? Whom can you turn to for emotional and other forms of support?

_____

_____

_____

Children

Please list your biological, adopted and/or stepchildren (if applicable)

First name	Biological, Adopted or Step	Current Age	School grade?	Male/ Female	Lives with you? (Yes/No)	Describe your relationship in a few words

Employment and/or Current Educational Situation

Are you currently employed? Yes No Are you currently a student? Yes No

Please describe your current work or academic situation: _____

_____

_____

Do you enjoy your work/school? Is there anything stressful about it? _____

_____

What are some of your interests & activities? _____

_____

_____

Do you consider yourself spiritual or religious? Yes No

Is so, describe your spirituality/faith and you level of participation in a faith-based group (if applicable) :____

_____

_____

How much are <u>each</u> of the following areas currently a problem for you?

	Not at all	**A little**	**Somewhat**	**Considerably**	**Terribly**
	1	**2**	**3**	**4**	**5**
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Family Conflicts	1	2	3	4	5
Marital Conflicts	1	2	3	4	5
Social Relationships	1	2	3	4	5
Job/School	1	2	3	4	5
Sexual Problems	1	2	3	4	5
Spiritual/religious	1	2	3	4	5
Legal Problems	1	2	3	4	5
Eating Disorder/Struggles	1	2	3	4	5
Abuse (physical, emotional, sexual)	1	2	3	4	5

Have you experienced any unusually severe stresses during the last year? Yes No
If yes, please describe:_____

_____

_____

What do you consider to be your strengths?_____

What do you consider to be your areas of needed growth?_____

Is there any other information you'd like to add? _____

_____