ASSESSMENT QUESTIONNAIRE

Please provide the following information for your file. This information is confidential.
Please leave blank any questions you do not wish to answer.

Name:_____

Name & Tel. of parent/guardian (if under 18 years old):_____

Referred by: _____

Date of Birth: _____/_____/_____ Age: _____

Marital Status: _____ Number of Children: _____

Address:_____

(Street & Number)

_____

(City) (State) (Zip)

Home Phone: ( ) May I leave a message? Y or N Yes
Cell Phone: ( ) May I leave a message? Y or N Yes
Work Phone: ( ) May I leave a message? Y or N Yes

Email: _____ May I email you? Y or N Yes

Person to contact in an emergency: _____ Contact Number: ( )

Please list any medications you are currently taking:_____

_____

Please list any psychiatric medications you have taken in the past: _____

_____

Are you currently receiving psychiatric and/or psychotherapy services? Y or N Yes

Psychiatrist's/ Psychotherapist's name: _____

OCCUPATION INFORMATION

Are you currently employed? Y or N Yes

What is your current position? _____

Please list any employment related stressors: _____

FAMILY HISTORY

Has any family member experienced any psychiatric problems? Y or N Yes

If yes, please detail: _____

HEALTH INFORMATION

Are you experiencing any health concerns?: _____

How would you rate your health? (please circle one) Excellent

Unsatisfactory Satisfactory Good Excellent

Do you have sleep problems? (Describe) _____

Do you exercise? Y or N Yes If yes, how many times a week? _____

Do have appetite difficulties or eating habit problems? Y or N Yes

(Circle where applicable): Eating less Eating more Binging Restricting Eating Less

Do you drink alcohol? Y or N. Yes If yes, how many units a week: _____

Do you use recreational drugs? Y or N. Yes If yes, what type and how often: _____

In the past year have you experienced any significant life stresses? Yes

Please list your sources of emotional support: _____

_____

Please check the following symptoms if you have experienced them:

	In the last seven days	In the past (approx. when?)
Depressed mood	☐	
Anxiety	☐	
Panic Attacks	☐	
Mood swings	☐	
Phobias	☐	
Obsessive thoughts	☐	
Repetitive behaviors	☐	
Intrusive thoughts re: trauma	☐	
Flashbacks re: trauma	☐	
Eating disorder	☐	
Body image problems	☐	
Alcohol and/ or substance abuse	☐	
Relationship difficulties	☐	
Learning disabilities	☐	
Neurological problems e.g. ADHD	☐	
Suicidal thoughts	☐	
Suicide attempt	☐	

What are your goals for therapy?

Anything else you think I should know?

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