Dr. Sarah Allen Counseling

ASSESSMENT QUESTIONNAIRE

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: Doctor / Friend / Family/ Online /Other (Please circle)_____

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

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

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

Email: _____ May I email you? Y or N

Would you like to be added to my newsletter email list (approx. 3-4 newsletters a year) Y or N

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

Psychiatrist's/ Psychotherapist's name: _____

OCCUPATION INFORMATION

Are you currently employed? Y or N

What is your current position? _____

Please list any employment related stressors: _____

FAMILY HISTORY

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

If yes, please detail: _____

HEALTH INFORMATION

Are you experiencing any health concerns?_____

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

Unsatisfactory Satisfactory Good Excellent

Do you have sleep problems? (Describe) _____

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

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

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

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

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

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

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?