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## Tampa, FL 33606
## (813) 368-2947


*Thank you in advance for your time in completing this confidential questionnaire. The information will help me understand your situation. When added to our meetings together, it will help us find an effective approach to the challenges we shall be considering together. Your replies will be held in confidence as required by law.*

Please add any information that you believe might be relevant, using the reverse sides of pages if necessary.

Name_____ Age_____ Date of Birth_____

Address _____City_____ Zip_____

Phone numbers: Home _____ Work_____

Do you authorize permission to call home phone number? Yes_____ No_____

Do you authorize permission to call work phone number? Yes_____ No_____

May I leave a message? Yes_____ No_____ If not, please specify which numbers_____

Occupation _____

Referred by: _____

In case of an Emergency, I should contact:

Name _____ Phone_____

Address _____ City_____ Zip_____

Relation_____

Please describe the reasons for coming to therapy at this time in your life._____

_____

_____

_____

_____

_____

How do you hope your life to be different at the end of therapy? _____

_____

_____

_____

*While it is impossible to create a form that will describe every family, I hope to better understand your situation through the completion of your family information. Feel free to add explanations or other information that you think would help provide an accurate picture of your family.*

Spouse(s): Age Years married/Year divorce Current City/State of residence residence

1._____

2._____

3._____

4._____

Children: Name Age Years married/Year divorce Current City/State of residence

1._____

2._____

3._____

4._____

5._____

Parents:

Mother's name: _____ Age: _____ Living? Yes ___ No ___

Occupation (current or prior): _____ Cause of death, if deceased:_____

If living, where?: _____ Married to other parent?: Yes ___ No ___

Remarried: Yes ___ No ___

Father's name: _____ Age: _____ Living? Yes ___ No ___

Occupation (current or prior): _____ Cause of death, if deceased:_____

If living, where?: _____ Married to other parent?: Yes ___ No ___

Remarried: Yes ___ No ___

Sibling(s): Name Age Current City/State of residence

1._____

2._____

3._____

4._____

Other significant family members, family you are especially close to, live or lived with, etc.:

1._____

2._____

3._____

4._____

*Have any family members had problems:*

With alcohol? Yes ___ No ___ How related? _____

With drugs? Yes ___ No ___ How related? _____

With their mental health? Yes ___ No ___ How related? _____

Attempted or committed suicide? Yes ___ No ___ How related? _____

**MEDICAL & TREATMENT HISTORY**

Primary care physician_____ Phone_____

Address _____ City_____ Zip_____

Date of your most recent physical examination _____

Have you had any illnesses in the past? Yes ___ No ___

If yes, which ones?_____

Do you have any illnesses at present? Yes ___ No ___

If yes, which ones? _____

Are those medical problems being treated? Yes ___ No ___

Which medications are you taking now (medical or psychiatric)?

Drug Dose Frequency Prescribing physician

_____

_____

_____

## MEDICAL & TREATMENT HISTORY CONTINUED

**Medication History**

Which medications have you taken in the past?

Drug Date Reason for discontinuing

_____

_____

_____

Do you drink alcohol? Yes ___ No ___

Have you ever tried to cut down on how much you drink? Yes ___ No ___

Do you smoke? Yes ___ No ___

If yes, what and how much?_____

Do you use any form of nonsmoking forms of tobacco? Yes ___ No ___

If yes, which?_____

Beverages with caffeine: *(Please check those that apply)* Yes ___ No ___

___ Coffee ___Tea ___ cups per day ___Colas ___ cans per day

Are you allergic to any medicines? Yes ___ No ___

If yes, please list:_____

Are you allergic to other substances? Yes ___ No ___

Have you had any surgical operations or injuries? Yes ___ No ___

Have you ever had a head injury? Yes ___ No ___

Have you ever had seizures? Yes ___ No ___

Previous Therapist(s) Reason Seen Dates Reason completed

_____

_____

_____

**BRIEF REVIEW OF CONCERNS**

Please check any concerns which pertain to you.

| | | |
|---|---|---|
| ___Stress | ___Anger | ___Dizziness/vertigo |
| ___Grief & Loss | ___Perfectionism | ___Sleep difficulty |
| ___Chest pain | ___Shortness of breath | ___Decreased energy |
| ___Difficulties with organization | ___Difficulty concentrating | ___Distractedness |
| ___Impulsiveness | ___Children | ___Abdominal pain |
| ___Eating problems | ___Guilt | ___Nightmares |
| ___Decreased appetite | ___ Marriage | ___Sexual Orientation |
| ___Nausea/vomiting/diarrhea | ___Weight loss/gain | ___Fearing failure |
| ___Breakup of Relationship | ___Frequent headaches | ___Flashbacks |
| ___Convulsions or seizures | ___Self-induced vomiting | ___Hopelessness |
| ___Depression | ___Anxiety/panic attacks | ___Spirituality |
| ___Decreased motivation | ___Racing thoughts | ___Loneliness/isolation |
| ___Suicidal thoughts/fears | ___Suicidal plan/attempts | ___Alcohol/Drug Use |
| ___Homicidal plans/violent acts | ___Homicidal thoughts | ___Making Decisions |
| ___Resentment | ___Friendships | ___Career Choices |
| ___Self-confidence | ___Legal Matters | ___Sexual Problems |
| ___Unclear Self-Image | ___Using laxatives, diuretics, or diet pills to lose weight | |

___Seeing things that other people don’t see

___Repetitive unwanted thoughts or actions

___Checking things multiple times to make sure they are in place

___Washing things multiple times to make sure they are clean

___ Hearing things that other people don’t hear

## PERSONAL HISTORY

Which stresses have you over come in the past? _____

_____

How did you do it? _____

_____

What was the best period of your life? _____

What are your personal strengths? _____

_____

What are your hobbies? _____

Do you practice a religion? Yes ___ No ___ If so, what? _____

If yes, describe your involvement with your religion_____

_____

If not, do you believe in God? Yes ___ No ___

Did you graduate from high school? Yes ___ No ___ Where? _____

Did you go to school after high school? Yes ___ No ___

Describe: _____

Have you had any history of difficulties at school? Yes ___ No ___

If yes, please describe: _____

_____

Have you had any history of difficulties at work? Yes ___ No ___

If yes, please explain: _____

## CONSENT TO TREATMENT

**I consent to psychotherapeutic evaluation and treatment. I have received a client handbook and agree with the terms stated therein.**

_____ _____

**Signature** **Date**