CONFIDENTIAL QUESTIONNAIRE
Behavioral Health Services

OUTPATIENT

Please take a few minutes to complete this questionnaire. This information will be helpful to us as we learn about your personal concerns. It is very important that you provide accurate information. This questionnaire will become part of your confidential medical record.

PLEASE COMPLETE ALL SECTIONS Today's Date: ____/____/____

PATIENT INFORMATION

Name: ______________________________ Birthday: ____/____/____ ______ Yrs.
Last First

Previous or Maiden Name: ____________________ Marital Status: ❒ Single ❒ Married ❒ Widow ❒ Divorced

Sex: ❒ Male ❒ Female

Mailing Address ______________________________
Street/Avenue Apt. #
____
City State Zip

Current Residence ______________________________
Street/Avenue Apt. #
____
City State Zip

Home Phone #: ____________ Daytime/Work #: ____________ Cell #: ____________

Preferred Method of Contact: ______________________________

Employment: ❒ Full Time ❒ Part Time ❒ Self-Employed ❒ Student
❒ Other: ______________________________

Employer: ______________________________

SPOUSE'S INFORMATION

Name: ______________________________
Last First

____
Street/Avenue Apt. # City State Zip

EMERGENCY CONTACT

Name: ______________________________ Relationship: ____________
Last First

______________________________ ____________ ____________
Street/Avenue Apt. # Home Phone # Daytime Phone #

____
City State Zip

Family Physician: ______________________________

INSURANCE INFORMATION

Primary Insurance: ____________________ Policy Holder: ____________
Group #: ____________________ DOB of Policy Holder: ____/____/____
Employer: ____________________ Contract #: ____________

Secondary Insurance: ____________________ Policy Holder: ____________
Group #: ____________________ DOB of Policy Holder: ____/____/____
Employer: ____________________ Contract #: ____________

CONFIDENTIAL QUESTIONNAIRE
Behavioral Health Services

Initial Assessment (Part I)

Name: ____ **Birthday:** ___/___/____ _____ **Yrs.**
Last First

What symptoms or problems bring you to this appointment? ______________________________
____
____
____
____

FAMILY INFORMATION

Who currently lives with you?

Name	Age	Relationship	Quality of Relationship

Do you have children living away from home?

Name	Age	Relationship	Quality of Relationship

Who do you have available for support?

Name	Age	Relationship

Marital Status

- ❒ Single
- ❒ Separated, length of time: ______________
- ❒ Divorce in progress, length of time: __________
- ❒ Divorced, length of time: ______________
- ❒ Unmarried, living together, length of time: __________
- ❒ Legally married, length of time: ______________
- ❒ Widowed, length of time: ______________

Assessment of current relationship: ❒ Good ❒ Fair ❒ Poor Number of marriages: __________

CHILDHOOD HISTORY

Number of siblings _____ Sisters: _____ Stepsisters: _____ Brothers: _____ Stepbrothers: _____
Your position from top of sibship: ______
Lived with: ❒ Parents _______ ❒ Parents and siblings ❒ Other ______________
Parents are/were: ❒ Married ❒ Divorced ❒ Separated
Mother's age _____ (If deceased, at what age ____. Your age at that time ____.) Stepmother: ❒ Yes ❒ No
Father's age _____ (If deceased, at what age ____. Your age at that time ____.) Stepfather: ❒ Yes ❒ No

EDUCATION

Highest grade level obtained: ______________________

List any barriers to learning (i.e. learning disability, vision or hearing impairment) ______________________

I learn effectively through: ❒ Speakers ❒ Video ❒ Audio tapes ❒ Written material

EMPLOYMENT

❒ Employed, Position: __________ ❒ Retired ❒ Unemployed, explain: __________

Concerns/Work Stress: ❒ None ❒ Yes, explain: ______________________

SOCIAL RELATIONSHIPS

Usual response to social relationships:

❒ Avoidant ❒ Shy/Withdrawn ❒ Follower ❒ Friendly

❒ Leader ❒ Argumentative ❒ Aggressive ❒ Outgoing

Are you satisfied with current social relationships? ❒ Yes ❒ No, explain: __________

Recent changes in social relationships? ❒ No ❒ Yes, explain: __________

FINANCIAL CONCERNS: ❒ No ❒ Yes, explain: ______________________

TREATMENT HISTORY

Have you had outpatient counseling or therapy before? ❒ No ❒ Yes

When and with whom? ______________________

Was it helpful? ❒ Yes ❒ No, explain: ______________________

Have you ever been treated with psychiatric medication(s) before? ❒ No ❒ Yes

When and with whom? ______________________

What medications? ______________________

Did you experience any side effects? ______________________

Have you ever been hospitalized for a psychiatric condition? ❒ No ❒ Yes

If yes, give admission(s) date, hospital, and reason for admission: __________

Have you ever made a suicide attempt? ❒ No ❒ Yes, explain: __________

Did you receive treatment for this? ______________________

CURRENT SUBSTANCE USE (check all that apply)

	Last Use Date/Time	Frequency	Dose/Amount
☐ None	-----	-----	-----
☐ Caffeine			
☐ Nicotine			
☐ Alcohol			
☐ Marijuana			
☐ Cocaine			
☐ Stimulants			
☐ Sedatives			
☐ Pain pills			
☐ Inhalants			

Have you experienced any consequences of usage?
☐ Social ________________ ☐ Occupational ________________
☐ Legal ________________ ☐ Other: ________________

Have you had treatment for a substance abuse problem? ☐ No ☐ Yes
If yes, list dates, place, and result: ________________

Check any word(s) that best describe(s) your current alcohol or drug use:
☐ Social ☐ None ☐ Alcoholic ☐ Addicted
☐ Dependent ☐ Minimal ☐ Experimental

FAMILY TREATMENT HISTORY

Is there any family history of mental health or psychiatric problems, alcoholism, or other substance abuse?
☐ No ☐ Yes If yes, please list below:

How is person related to you?	Type of Problem	Treatment/ Medications	Helpful?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Is there any history of suicide in your family? ☐ No ☐ Yes If so, what relation to you:

DEVELOPMENT

History of abuse or trauma? ☐ No ☐ Yes If yes, type: ☐ Sexual ☐ Physical ☐ Emotional
Abuse was as: ☐ Victim ☐ Perpetrator Explain: ________________
Problems transitioning from one life stage to another? ☐ No ☐ Yes
If yes, please explain: ________________

CULTURAL/ETHNIC

Are there any cultural or ethnic issues you would like us to be aware of? ❐ No ❐ Yes

Explain: ______________________________

____

SPIRITUAL/RELIGIOUS

Do you have a supportive faith community? ❐ No ❐ Yes

How important have spiritual matters been? ❐ Minimal ❐ Moderate ❐ High

Spiritual needs? ❐ No ❐ Yes Explain: ______________________________

____

LEISURE/RECREATIONAL

What hobbies or activities are you interested or involved in?

Activity	Recent Changes
____________	❐ No ❐ Yes Explain: ____________
____________	❐ No ❐ Yes Explain: ____________
____________	❐ No ❐ Yes Explain: ____________

MILITARY HISORY

❐ No ❐ Yes If yes: Branch: ______________________________

Type of Discharge: ______________________________

Length of Service: ______________________________

Comments (optional): ______________________________

LEGAL

Present legal involvement: ❐ None ❐ On Probation ❐ On Parole

Probation/parole officer: ❐ No ❐ Yes Name: ______________________________

Pending legal charges: ❐ No ❐ Yes Explain: ______________________________

Past legal charges: ❐ No ❐ Yes Explain: ______________________________

____

ADDITIONAL COMMENTS (If needed):

Is there anything else about you that may be important for us to know so we may be of help to you?

____

____

____

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____

PERSONAL CHECKLIST: Check any of the following that apply to you within the past **two weeks**:
(Rate for severity: 1 = mild 2 = moderate 3 = severe)

____ depressed
____ sad
____ crying spells
____ feeling hopeless
____ feeling helpless
____ feeling worthless
____ suicidal thoughts
____ lack of energy
____ hard to concentrate
____ daydream too often
____ trouble falling asleep
____ trouble staying asleep
____ problems with memory
____ can't make decisions
____ excessive appetite
____ lack of appetite
____ loss of weight
____ weight gain
____ not enjoying things
____ unable to have fun
____ grouchy
____ irritable
____ quick-tempered
____ feeling easily hurt
____ dislike vacations
____ dislike weekends
____ dread holidays
____ don't like being alone
____ impatient with people
____ overly sensitive
____ shyness
____ feeling inferior
____ critical of self
____ critical of others
____ lack self-confidence
____ hide behind a mask
____ "live" in the past
____ bored often
____ lonely
____ empty

____ loss of sexual interest
____ sexual problems
____ feel like smashing things
____ feel like hurting someone
____ fight / quarreling
____ overly ambitious
____ too much energy
____ naturally "wired"
____ mood swings
____ racing thoughts
____ invincible
____ creative
____ can't sit still
____ driven
____ little need for sleep
____ jittery
____ fidgety
____ unable to relax
____ anxious inside
____ nervous
____ feeling tense
____ always worried
____ frightening images
____ feeling panicky
____ fearful
____ hands shaky
____ easily startled
____ vague disturbing memories
____ nightmares
____ fainting spells
____ fast heartbeat
____ sweaty hands
____ frequent sweating
____ short of breath
____ muscles tight
____ muscles ache
____ muscles "jumping"
____ light headed
____ dizzy spells
____ headaches

___ constipation
___ stomach troubles
___ "butterflies" in stomach
___ vomiting
___ diarrhea
___ picking at skin/hair
___ hands and feet cold
___ can't be in crowds
___ don't want to be embarrassed
___ counting things over & over
___ checking things over & over
___ repetitive thoughts
___ perfectionistic
___ must do certain acts
___ problems at work
___ problems w/spouse (partner)
___ problems w/parents
___ problems w/children
___ problems w/family
___ financial problems
___ can't handle money
___ obsess about problems
___ can't hold a job
___ use of medication
___ drug use
___ excessive alcohol
___ blackouts
___ passing out
___ DWI(s)
___ lost job due to drinking/drugs
___ people have it in for me
___ always early for things
___ always late for things
___ worry about health
___ worried about aging
___ worried about death
___ poor health
___ no one understands me
___ can't make friends

H & P Medical Summary List

Do you have any current medical conditions? ❒ No ❒ Yes (If yes, please list below)

____

CURRENT MEDICATIONS

(Include non-prescription meds, vitamins, and herbal remedies.)	Dose	Taken how often?	Reason	Who Prescribed?
1.				
2.				
3.				
4.				

Are you allergic to any medications? ❒ No ❒ Yes Which ones? ______________

What kind of reactions do you have? ______________

HEALTH FACTORS - Do you have any history of . . .

	No	Yes		No	Yes
Cancer			Blood Sugar Problems		
Heart Problems			Thyroid Disease		
Seizures			Eye Diseases		
Head Injuries			Prostrate Problems		
Kidney Problems			PMS		
Liver Problems			Other (please describe)		

Describe: ______________

NUTRITION

Do you have a history of having unintentional weight gain or loss? ❒ Yes ❒ No

CHRONIC PAIN

Do you have a history of chronic pain? ❒ No ❒ Yes Describe: ______________

Rate current level of pain – '1-10' ('1'-lowest, '10'-highest): ______________

Current Treatment: ______________

SURGICAL

Please list surgeries and dates: ______________

Date of last contact with Primary Care Physician: ___/___/___ Date of last physical: ___/___/___

Any problems found? ______________

In the past year, have you received: ❒ Flu Shot (when) ______________

❒ Pneumonia Vaccination (if over 65) (when) ______________

Are your immunizations up to date? ❒ Yes ❒ No

If no, please contact your primary care physician for immunization update.

SEXUAL

Do you use birth control? ❒ Yes ❒ No ❒ N/A What kind? ______________

Have you every had a sexually transmitted disease? ❒ No ❒ Yes ❒ N/A

If yes, please explain: ______________

FEMALES ONLY

Are your periods regular? ❒ Yes ❒ No ❒ N/A Date of last period? ______________

Do you experience severe mood swings? ❒ Yes ❒ No ❒ N/A

Is there any possibility you may be pregnant? ❒ Yes ❒ No ❒ N/A