CLIENT INFORMATION:

Today's Date: _____

Name: _____ Date of Birth: _____
Last name, first name

PSYCHOSOCIAL HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your record.

CURRENT CONCERNS

Briefly describe the concerns you would like to address.			
What is your goal for treatment?			
Were you referred to this office? By Whom?		**How did you find out about this office?**	

PERSONAL HEALTH HISTORY

Name of Primary Care Physician:	Phone:	Fax:	Date of last visit:

Please check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐	Skin	☐	Chest/Heart/Circulation		**Recent changes in:**
☐	Head/Neck	☐	Bladder/Bowel	☐	**Weight**
☐	Ears/Nose/Throat	☐	Intestinal	☐	**Energy level**
☐	Lungs	☐	Other: _____	☐	**Ability to sleep**

Please list any medical problems that doctors/medical providers have diagnosed:

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers (use other side of page if needed)

Name the Drug (Prescriber if different than your primary physician)	Strength/Dose	Frequency Taken	Outcome since starting the medication		
			☐ Better	☐ Worse	☐ Same
			☐ Better	☐ Worse	☐ Same
			☐ Better	☐ Worse	☐ Same
			☐ Better	☐ Worse	☐ Same

Allergies to medications/food/environment (use other side of page if needed)

Name the allergen (drug/food/environment)	Reaction You Experience

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Other: _____
	☐ Developmental problems or Genetic Disorders Specify: _____

Surgeries (use other side of page if needed)

Year	Reason	Hospital	Outcome since surgery		
			☐ Better	☐ Worse	☐ Same
			☐ Better	☐ Worse	☐ Same

Other hospitalizations (include inpatient/outpatient chemical dependency, psychiatric services, use other side of page if needed)

Year	Reason	Hospital	Outcome since Hospitalization		
			☐ Better	☐ Worse	☐ Same
			☐ Better	☐ Worse	☐ Same

SPIRITUAL ASSESSMENT										
Do you consider yourself spiritual or religious?	☐ Yes ☐ No ☐ I choose not to answer									
Are you part of a spiritual or religious community?	☐ Yes ☐ No ☐ I choose not to answer If **YES**, please indicate your Faith/Religion/Spiritual Affiliation:_____									
How important is your faith or spiritual/cultural beliefs to you in life? (place a check in the corresponding box)										
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐10	
No Opinion	Not Important At All		Not Very Important			Mildly Important			Very Important	
How have your beliefs or practices influenced how you take care of yourself during illnesses or during difficult times? _____	☐ I choose not to answer									
Would you like your counselor to address these issues in your treatment?	☐ Yes	☐ No need to address	☐ I choose not to answer							

HEALTH HABITS AND PERSONAL SAFETY						
Exercise (check one)	☐ Sedentary (No exercise) ☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf) ☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?	☐	Yes	☐	No	
	If yes, are you on a physician prescribed medical diet? _____	☐	Yes	☐	No	
	Number of meals you eat in an average day? _____					
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola/Soda		
	Number of cups/cans per day? _____					
Alcohol and Marijuana	Do use marijuana or marijuana products? If yes, circle if use is medicinal or recreational.	☐	Yes	☐	No	
	How often do you use marijuana? ☐Monthly ☐Weekly ☐Daily ☐more than once/day ☐Other_____					
	Do you drink alcohol?	☐	Yes	☐	No	
	If yes, what kind? _____ How many drinks per week? _____					
	Have you ever experienced blackouts?	☐	Yes	☐	No	
	Are you prone to "binge" drinking?	☐	Yes	☐	No	
	Do you drive after drinking or using marijuana?	☐	Yes	☐	No	
	Have you been arrested while driving under the influence of alcohol or drugs?	☐	Yes	☐	No	
Tobacco	Do you use tobacco? If yes, how much/day? _____	☐	Yes	☐	No	
	☐ Number of years (How Long?) _____	☐ Or year quit _____				
Drugs	Do you currently use any prescription pain killers or other prescription drugs without a doctor's prescription?	☐	Yes	☐	No	
	Do you currently use recreational or street drugs?	☐	Yes	☐	No	
	Have you ever given yourself street drugs with a needle?	☐	Yes	☐	No	
Sex	Are you sexually active?	☐	Yes	☐	No	
	If yes, are you trying for a pregnancy?	☐	Yes	☐	No	
	If not trying for a pregnancy list contraceptive or barrier method used:_____					
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐	Yes	☐	No	
Personal Safety	Physical and mental abuse have become major public health issues in this country. This often takes the form of verbal threats or actual physical or sexual abuse. Would you like to discuss this issue with your clinician?	☐	Yes	☐	No	
Education and Occupation	Did you receive a diploma or GED? Highest degree awarded: _____	☐	Yes	☐	No	
	Did you attend Special Education classes?	☐	Yes	☐	No	
	Did you experience any learning difficulties during school?	☐	Yes	☐	No	
	Are you currently employed? Position & Employer:_____	☐	Yes	☐	No	
	What is your current source of income? _____	☐ No Income				

FAMILY HEALTH HISTORY (please use other side of page if needed)					
	AGE	**SIGNIFICANT HEALTH PROBLEMS**		**AGE**	**SIGNIFICANT HEALTH PROBLEMS**
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Siblings	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

PAIN SCREENING				
Are you currently experiencing pain?	☐	Yes	☐	No
If "***Yes***" is this pain chronic? ☐ Yes ☐ No	Where is your pain located?			
On a scale of one to ten please indicate how severe you feel this pain is **today** (1 is the least 10 is the most). ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐10 (Little or no pain.....Moderate Pain.....Severe Pain)				

SYMPTOM REVIEW				
Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks?	☐	Yes	☐	No
Have you felt sad, low or depressed for the past two years?	☐	Yes	☐	No
Are you feeling suicidal?	☐	Yes	☐	No
Have you ever attempted suicide?	☐	Yes	☐	No
Have you ever thought about hurting or killing another person?	☐	Yes	☐	No
Have you ever had a period of time when you were feeling "up" or "high" or so full of energy that you got into trouble or that other people thought you were not your normal self?	☐	Yes	☐	No
Have you been feeling irritable, or do you find yourself frequently starting fights with other people?	☐	Yes	☐	No
Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way?	☐	Yes	☐	No
Have you ever felt anxiety or panic when you were in a crowd, standing in a line or while alone in your car, crossing a bridge or traveling by airplane, train, bus or car?	☐	Yes	☐	No
In the past month, were you fearful or embarrassed about being watched, the focus of attention, or fearful of being humiliated? This includes times like speaking in public, eating in public or with others, writing while someone watches, or in social situations?	☐	Yes	☐	No
In the past months have you been bothered by recurrent thoughts, impulses or images that were unwanted, distasteful, inappropriate, intrusive or distressing? (For example, the idea you were dirty, contaminated or had germs.)	☐	Yes	☐	No
Do you experience frequent or recurrent nightmares?	☐	Yes	☐	No
Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else?	☐	Yes	☐	No
Have you ever experienced abuse (physical, sexual, verbal) or neglect?	☐	Yes	☐	No
Have you ever believed that people were spying on you, or conspiring against you?	☐	Yes	☐	No
Have you ever believed that someone was reading your mind, or that you could read someone's mind, or hear what another person was thinking?	☐	Yes	☐	No
Have you ever experienced hallucinations (visual, auditory, tactile)?	☐	Yes	☐	No
Do you have difficulty sitting still or paying attention? Are you easily distracted, find yourself daydreaming or "spacing off."	☐	Yes	☐	No

Additional comments or information you think is important: (use other side of page if needed)

_____

_____

_____

Thank you for completing this survey!

DOCUMENT REVIEWED BY: _____ DATE: _____