CLINICAL QUESTIONNAIRE

(Patients 18 years old and up)

This questionnaire is designed to supply your therapist with comprehensive information about your past history and present situation. By completing these questions as fully and accurately as you can, you will facilitate your clinical assessment and therapy program. Thank you.

1. General Information:

Date:_____

Name: _____Spouse name:_____

Address: _____ Sex: Male Female

_____ Age:_____ Date of Birth: _____

Phone number:_____ ☐ Home ☐ Cell ☐ Work

Phone number:_____ ☐ Home ☐ Cell ☐ Work

Marital Status (please check one of the following):
□ Single □ Engaged □ Married □ Divorced □ Remarried □ Living together □ Widowed

Do you have any children? Yes____ No_____

If so, please list names and ages below:

NAME:	AGE:	/	NAME:	AGE:
_____	_____	/	_____	_____
_____	_____	/	_____	_____
_____	_____	/	_____	_____
_____	_____	/	_____	_____

Primary Care Physician (PCP): _____

Address: _____

Health Insurance: _____

2. Current Clinical Data:

(a.) Describe the main problem(s) that led you to seek therapy at this time, including the duration of this problem (or set of problems):

(b.) Have you ever received any mental health, outpatient/inpatient treatment if yes, where and when?

(c.) Family Functioning: Briefly describe how *the problems you are having,* have been affecting your relationship with family members (i.e. spouse, partner, children and other significant relatives):

(d.) Social Functioning: Briefly describe how *the problems you are having,* have been affecting your social functioning with non-family members (i.e. relationship with friends):

(e.) Work/ School Functioning: Briefly describe any ways that you feel your functioning at work and, if relevant, at school, has been affected by *your current problem(*s) (i.e. performance levels, relationship with co-workers):

(f.) Please place a checkmark in the appropriate box for each of the following:

Have you ever:	**Present**	**Past**	**Never**
1. Purposely injured yourself without suicidal intent (e.g. cut, hit, burned, etc.)			
2. Seriously considered attempting suicide			
3. Made a suicide attempt			
4. Considered seriously injuring another person			
5. Intentionally caused serious injury to another person			
6. Had unwanted sexual contact(s) or experience(s)			
7. Experienced harassing, controlling, and/or abusive behavior from another person (e.g., friend, family member, partner, or authority figure)			
8. Been hit, punched, slapped, kicked, or otherwise physically harmed by a person (e.g. friend, family, partner, or authority figure) with cruel or malicious intent			
9. Been involved in child abuse a.) as a victim/survivor b.) as a perpetrator			
10. Been involved in sexual abuse a.) as a victim/survivor b.) as a perpetrator			
11. Had an eating disorder			
12. Felt that something was wrong with your mind			
13. Physically threatened another person			
14. Assaulted or attempted to kill another person			
15. Felt your thoughts were so loud people could hear them			
16. Had periods of time you can't account for			
17. Had periods of severe depression			
18. Believed others were conspiring against you			
19. Had periods in which you felt extremely optimistic, full of energy, could get by on little or no sleep, and/or thought and talked very fast			
20. Felt compelled to help other people			
21. Felt compelled to isolate yourself			

(g.) Please describe your experiences with each of the following:

Substance	Amount of Use	Frequency of Use	Age at First Use	Age at Last Use	Used in Last 48 Hours		Used in Last 6 Months	
Alcohol					Y	N	Y	N
Nicotine					Y	N	Y	N
Marijuana					Y	N	Y	N
Other (fill in):					Y	N	Y	N
Other (fill in):					Y	N	Y	N
Other (fill in):					Y	N	Y	N
Other (fill in):					Y	N	Y	N

1. Have you ever tried to cut down on your drinking and/or drug use? ☐Yes ☐No

2. Have you ever been annoyed at other's complaints about your use? ☐Yes ☐No

3. Have you ever felt guilty about your use? ☐Yes ☐No

4. Have you ever used alcohol or drugs first thing in the morning to avoid a hangover? ☐Yes ☐No

5. Is there any family history of drug or alcohol use? ☐Yes ☐No
   If yes, please describe:

6. Is there any family history of psychiatric conditions or treatment? ☐Yes ☐No
   If yes, please describe:

3. Social/Educational/Employment/Legal Data

(a.) Indicate the highest level of formal education that you have obtained:_____

(b.) Indicate your current occupation:_____

(c.) Were you ever in the military? ☐Yes ☐No

(d.) Have you ever been arrested? ☐Yes ☐No
   If yes, briefly describe what this involved:

4. Medical Data

(a.) If you have had any past or current medical illnesses or surgeries, give a brief description of these, including when they occurred:

Date(s)	Incident	Treating Physician

(b.) List any current medications, including dosage, that you take:

Medication	Dosage	Reason Taken	# of times of day taken	# of days a week taken	Prescribing Physician
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	

(c.) Do you have any allergies to medications? If yes, please explain:

(d.) The date of your last physical: _____

Is there anything else that you'd like to share?

My signature below indicates that I have completed this form as completely and accurately as possible.

_____

Patient Name Signature Date