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By completing this questionnaire prior to our first appointment, you will be helping me to better understand your questions and the concerns that may be affecting you. This information will also provide me with a great deal of important information which will enable us to work together most effectively. Please answer each of these questions as completely as possible.

Please return this information and any attached forms at least one week prior to our appointment so that I have the opportunity to preview this information before your visit.

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Name:_____ Date of birth:_____ Gender: M/F

Address: _____ City: _____ Zip:_____

Home/evening phone: _____ Work/daytime phone: _____

Cell phone: _____ e-mail: _____

Who referred you to this office? _____

Purpose of visit:

What types of services are you hoping to receive? (please check any/all that apply)

____ diagnosis
____ developmental/cognitive assessment
____ academic assessment
____ emotional/psychological assessment
____ individual psychotherapy
____ family therapy services
____ enhancement of parenting skills

Please describe the concerns you are having and/or the reasons for seeking psychological services:

How have these problems been affecting you or your family's daily life?

When did these problems first begin?

Have you previously received any type of evaluation or treatment for these issues? __ Yes __ No
If yes, when did this occur and with whom?

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services for any other reasons in the past? __ Yes __ No If yes, please describe below:

When? For what types of concerns? With whom did you work? Length of treatment?

School and Occupational History:

What was the highest level of education you completed? _____

When did you last attend any formal educational program? _____

Current occupation: _____

Place of employment: _____ Typical work hours: _____

Previous occupation: _____

Family of Origin:

Please check all information which applies to your biological parents:

MOTHER: ___ Living ___ Deceased (if yes, when? _____) ___ Married ___ Divorced ___ Remarried

FATHER: ___ Living ___ Deceased (if yes, when? _____) ___ Married ___ Divorced ___ Remarried

Do you consider anyone else (step-parent, grandparent, adoptive parent, etc.) to be one or both of your "real" parents?

If so, whom? _____

Where do your parents currently live? Mother: _____

Father: _____

Describe your relationship with your mother while growing up: _____

_____

Describe your current relationship with your mother: _____

_____

Describe your relationship with your father while growing up: _____

_____

Describe your current relationship with your father: _____

_____

List first names and current ages of brothers and sisters:

Name:	Current Age:	Where do they live?	Occupation:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe any family problems which occurred while growing up related to:

Alcohol or drug use: _____

_____

Physical / Emotional /Sexual abuse: _____

_____

Your Relationship / Marital History:

Marital status: ___ Single ___ Married ___ Separated ___ Divorced ___ Widowed ___ Living with someone

If married, date of anniversary: _____ If living with someone, how long? _____

If divorced, date of divorce: _____

Please list your children:

Name:	Age:	Gender	Relationship (Biological / step-child)	Child lives with:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list **all** people with whom you are **currently** living:

Name:	Age:	Gender	Relationship (spouse/partner, child/stepchild, parent, other)
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

During the last 12 months, have you or anyone in your family experienced any of the following:

Death of a family member ____
Serious illness ____
Unemployment ____
Marital problems ____
Other (please describe) ____

Have any other family members had any health problems or medical symptoms during the past 3 years (including headaches, back pain, stomach problems, problems with nerves, asthma or other breathing problems, diabetes, heart problems)? If yes, please list family members and the symptoms they experienced:

Family member	Medical symptoms / issues
_____	_____
_____	_____
_____	_____
_____	_____

Medical History:

Name of your Primary Care Doctor? _____

Your doctor's mailing address and phone number:

Address: _____

Phone: _____

How long have you been seeing this doctor? _____

When was your last medical examination? _____

Are you currently taking **any** medications? ___ Yes ___ No

If yes, please list each medication and the reason you are taking each medication:

Name of medication	Dose /Frequency	Reasons for taking this medicine
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been hospitalized? ___ Yes ___ No
If yes, please list ages and reasons:

Have you ever had surgery? ___ Yes ___ No
If yes, please list ages and reasons:

Have you ever had any serious accidents? ___ Yes ___ No
If yes, please describe:

Have you ever had a head injury? ___ Yes ___ No
If yes, please list ages and describe what happened:

Do you experience frequent headaches? ___ Yes ___ No

Do you experience frequent stomachaches? ___ Yes __ No

Do you have concerns about your sleeping habits/patterns? ___ Yes ___ No
If yes, please describe:

Have you ever been physically abused? ___ Yes ___ No
If yes, did you receive medical treatment? ___ Yes ___ No
If yes, did you receive any psychological treatment? ___ Yes ___ No
If yes, were the police or Child Protective Services contacted? ___ Yes ___ No

Have you ever been sexually abused? ___ Yes ___ No
If yes, did you receive medical treatment? ___ Yes ___ No
If yes, did you receive any psychological treatment? ___ Yes ___ No
If yes, were the police or Child Protective Services contacted? ___ Yes ___ No

Do you currently drink? __ Yes __ No
If yes, have you ever felt the need to cut back on your drinking? __ Yes __ No
Have you ever felt annoyed by criticism about your drinking? __ Yes __No
Have you ever felt guilty about your drinking? __ Yes __ No
Have you ever felt the need/desire for a morning "eye-opener"? __ Yes __ No
During the last 2 weeks, how many times did you drink (number of days)? ____

Do you currently use marijuana __ Yes __ No
If yes, have you ever felt the need to cut back on your use? __ Yes __ No
Have you ever felt annoyed by criticism about your use? __ Yes __No
Have you ever felt guilty about your use of marijuana? __ Yes __ No
During the last 2 weeks, how many times did you get high? ____

During the last 2 weeks have you used any other recreational / street drug(s)? __ Yes __ No If yes, please list:

Do you participate in any regular exercise? __ Yes __ No Describe:

How do you typically care for yourself emotionally? What have you found helpful? Please describe:

Medical history of your *biological* family:

Has anyone in your biological family ever experienced any of the following? Check all that apply.

	Birth Mother	Birth Father	Mother's Family	Father's Family	Siblings of patient
Alcoholism					
Birth defects					
Drug abuse					
Mental retardation					
Other developmental disabilities					
Learning disorders					
Attention Deficit/ADD/ADHD					
Seizures					
Headaches					
Neurologic disease					
Diabetes					
Heart disease					
Other lung/breathing problems					
Tics/Tourette's syndrome					
Genetic disorders					
Depression					
Suicide					
Anxiety problems					
Schizophrenia					
Hearing problems					
Vision problems					
Child abuse					
Sexual abuse					
Other _____					

Does anyone in your current family consume alcohol on a regular basis?

Partner/spouse	___ Yes	___ No
Child	___ Yes	___ No
Mother	___ Yes	___ No
Father	___ Yes	___ No
Siblings	___ Yes	___ No
Others (please describe)	____Yes	___ No

Does anyone in your current family use any street (recreational) drugs?

Partner/spouse	___ Yes	___ No
Child	___ Yes	___ No
Mother	___ Yes	___ No
Father	___ Yes	___ No
Siblings	___ Yes	___ No
Others (please describe)	____Yes	___ No

Significant Events:

Have you ever experienced any frightening or traumatic events? ___ Yes ___ No If yes, please describe:

Have any anniversaries of important or stressful events in your life occurred recently, or are any due to occur soon? __ Yes __ No If yes, please describe:

Are there any other significant events in your life that you feel would be important for me to be aware of or understand?

Miscellaneous, but very important questions:

List three things that you like about yourself:

1)

2)

3)

******* Please assume, for a moment, that our work together is extremely helpful to you; describe how you picture your life being different (better!) than it was before our work began:

Thank you very much for completing this questionnaire. I realize that it is long and required a great deal of your time. Please be assured, however, that this will be extremely helpful in our work together as we develop a pathway for positive changes. I look forward to seeing you for our first appointment.