

Please complete this questionnaire to help us learn more about you.

**A. General Information**

Name: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  Male  Female

Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_ Race: \_\_\_\_\_

Who referred you to this practice: \_\_\_\_\_

**B. Family Constellation**

Please list those individuals with whom you are living.

Name	Age	Relationship

**C. Problem Summary**

Briefly describe the specific problem(s) you wish to change. Please estimate the length of time the problem has been present:

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#### D. Current Symptoms

Check all that apply to how you are currently feeling.

1. I am feeling sad, blue, empty or depressed. If yes, for how long \_\_\_\_\_
2. I am finding it hard to enjoy things I used to enjoy. If yes, for how long \_\_\_\_\_
3. My sleep patterns are disrupted (trouble falling asleep, staying asleep, waking early and not being able to go back to sleep). If yes, describe \_\_\_\_\_  
I get about \_\_\_\_\_ hours of sleep each night.
4. I have lost my energy or feel fatigued. If yes, for how long \_\_\_\_\_
5. I cannot concentrate like I used to. If yes, for how long \_\_\_\_\_
6. It is harder for me take decisions than it used to be. If yes \_\_\_\_\_
7. I am having a lot of memory problems. If so, describe \_\_\_\_\_  
\_\_\_\_\_
8. I have been thinking of death or suicide a lot. If yes, describe \_\_\_\_\_  
\_\_\_\_\_
9. I am irritable and /or anxious a lot of the time. If yes, for how long \_\_\_\_\_
10. I have lost interest in sex or am having sexual difficulties. If yes, for how long \_\_\_\_\_
11. My appetite has changed a lot. If so, describe \_\_\_\_\_  
I have gained \_\_\_\_\_ pounds. I have lost \_\_\_\_\_ pounds.
12. I have a lot of physical symptoms that cannot be explained.  
If so, please describe \_\_\_\_\_
13. I have thoughts that intrude on my mind and refuse to go away.  
If yes, for how long \_\_\_\_\_
14. I am experiencing heart palpitations, shortness of breath and/or shakiness that come out of the blue. If yes, describe \_\_\_\_\_
15. I find myself avoiding places that I associate with my anxiety attacks. If yes, describe \_\_\_\_\_  
\_\_\_\_\_
16. I find I feel better if I engage in certain rituals, like washing my hands or checking things over and over. If yes, describe \_\_\_\_\_
17. I feel tense or on edge a lot. If yes, describe \_\_\_\_\_
18. It is hard for me to accept anything that is less than perfect. If yes, describe \_\_\_\_\_  
\_\_\_\_\_
19. I find myself reliving upsetting events from my past. If yes, describe \_\_\_\_\_  
\_\_\_\_\_
20. I am feeling hopeless. If so, for how long \_\_\_\_\_
21. I am having a lot of trouble in my relationships. If so, describe \_\_\_\_\_  
\_\_\_\_\_
22. I am having trouble at work or school. If so, describe \_\_\_\_\_  
\_\_\_\_\_

23. I have attempted suicide or tried to hurt myself in the past. If so, describe \_\_\_\_\_  
 \_\_\_\_\_
24. I am currently thinking about harming or killing someone else. If so, describe \_\_\_\_\_  
 \_\_\_\_\_
25. In the past, I have gotten so mad at someone that I seriously thought about or went about trying to kill them. If so, describe \_\_\_\_\_  
 \_\_\_\_\_
26. What else about your current symptoms would it be helpful to know?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### E. Alcohol and Drug Use

1. Do you drink alcohol? \_\_\_\_ Yes \_\_\_\_ No  
 If yes, please answer the following questions, if no, please skip to question # 2
- a) How many drinks do you have in an average week? \_\_\_\_\_
  - b) What is the **most** you can drink in one sitting? \_\_\_\_\_
  - c) How often have you surprised yourself with how much you have been able to drink?  
 \_\_\_\_ frequently \_\_\_\_ occasionally \_\_\_\_ never
  - d) In the past 3 years about how many times have you been unable to recall everything you did while drinking the night before? \_\_\_\_\_
2. Do you use street drugs (i.e. marijuana, cocaine, etc)? \_\_\_\_ Yes \_\_\_\_ No
- a) How much do you use in an average week? \_\_\_\_\_
  - b) What is the **most** you can use in one sitting? \_\_\_\_\_
  - c) How often have you surprised yourself with how much you have been able to use?  
 \_\_\_\_ frequently \_\_\_\_ occasionally \_\_\_\_ never
  - d) In the past 3 years about how many times have you been unable to recall everything you did while drinking the night before? \_\_\_\_\_
3. Have you had arguments with significant people in your life because they seem overly concerned about your drinking or drug use? \_\_\_\_ Yes \_\_\_\_ No
4. Have you found the need to avoid the issue of your drinking or drug use with a significant person because it seems to create a lot of disagreements and conflict? \_\_\_\_ Yes \_\_\_\_ No
5. Have you ever had a DUI or been arrested for drugs? \_\_\_\_ Yes \_\_\_\_ No
6. Have you ever been in rehab. or detox. for alcohol or drugs? \_\_\_\_ Yes \_\_\_\_ No
7. Do you smoke cigarettes? \_\_\_\_ Yes \_\_\_\_ No If yes, how many per day? \_\_\_\_\_
8. Do you drink caffeinated beverages? (coffee, tea, soda, etc) \_\_\_\_ Yes \_\_\_\_ No If yes, how many per day? \_\_\_\_\_

F. Medical and Physical History

Who is your Primary Care Physician? \_\_\_\_\_

PCP Address: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Please list all of your medical hospitalizations

Dates	Reason	Hospital	Physician

Please circle all of the medical problems that you are experiencing:

- Cancer
- Epilepsy (seizures)
- Arthritis
- Chronic Pain
- Digestive Problems
- Multiple Sclerosis
- Gynecological
- Hypertension
- Diabetes
- Heart Problems
- Breathing Problems
- Head Injury
- Genital/Urinary Problems
- Headaches
- Stroke
- Other: \_\_\_\_\_

If you are being treated for any of the above, please describe:

\_\_\_\_\_  
\_\_\_\_\_

List all prescribed and over the counter medications you take regularly:

\_\_\_\_\_  
\_\_\_\_\_

List any drug, medication or other substance to which you are **allergic**:

\_\_\_\_\_  
\_\_\_\_\_

Do you exercise regularly? \_\_\_ Yes \_\_\_ No

Do you eat a well-balanced diet? \_\_\_ Yes \_\_\_ No

### G. Previous Behavioral Health Treatment

Please list all of the behavioral health and chemical dependency treatment you have had.

Dates	Therapist or Hospital	Problem(s)	Medication(s)

### H. Family History

Please list family members who have been treated for emotional problems (e.g. anxiety, depression, schizophrenia, suicide), drug/alcohol issues or brain disease (e.g. Alzheimer's, stroke): \_\_\_\_\_

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### I. Other

Are you currently involved in court proceedings or litigations such as child custody, worker's compensation, auto accident or criminal proceedings? Please explain:

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Please add any additional information that you believe may be helpful:

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