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INTRODUCTION QUESTIONNAIRE

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____

Address:_____

City_____Zip_____

Home Phone:_____Work:_____Cell:_____

E-mail:_____

Birth Date: _____ /_____ /_____ Age: _____ Social Security_____

Relationship Status_____

Please list any children/age: _____

Employed By:_____Occupation:_____

Employer Address:_____

Insurance Provider:_____Policy Number:_____

Authorization Number:_____

Who Is The Primary on Your Policy:_____SSN#_____DOB:_____

Referred by (if any): _____

Have You Been In Therapy Before? If so, How Long?_____

List Any Medications You Are Taking, Dosage, And How Long You've Been Taking Them
_____
_____
Who Is Prescribing Your Medication?_____

Who Is Your Primary Care Physician?_____

List Any Major Health Problems You May Have_____
_____

Are You Now or Have You Ever Used Drugs?_____If So, Which Ones_____
_____
How Often Do You Use Them?_____

Do you drink alcohol more than once per week?_____How often & amount_____

Please list any health problems you are currently experiencing_____
_____

Are you experiencing any sleep difficulties? If so, describe_____
_____

Are you experiencing eating difficulties? _____

How many times per week do you generally exercise?_____What type_____

What significant life changes or stressful events have you experienced recently?_____
_____

Please check any of the following problems or symptoms you are experiencing:

___Depression	___Mood swings	___Difficulty concentrating
___Suicidal thoughts	___General anxiety	___Drinking problem
___Obsessive thoughts	___Panic attacks	___Excessive worry
___Distrust of people	___Phobias	___Low self-esteem
___Sexual dysfunction	___Guilt feelings	___Rages
___Problems with parents	___Shyness	___Low energy
___Problems with children	___Loneliness	___Isolation
___Compulsive sexual behavior	___Stress feelings	___Drug problem
___Stress headaches	___Relationship conflict	___Taken advantage of
___Difficulty making decisions	___Financial fears	___Destructive behavior

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

Any other information you feel would be helpful to your treatment?_____
_____
_____

Signature_____Date_____