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Get it in gear

New Patient Questionnaire

Name: _____ Date of Birth: _____ Age: _____

Date of Appointment: _____ Time of Appointment: _____ AM PM

Sex: _____ Race: _____ Religious Preference: _____

Marital Status: Married: # of years _____, Separated, Divorced, Widowed, Single

Referred By: _____

(e.g., Name of physician, website, friend, name of school counselor, yellow pages, etc.)

I am being referred for/coming to therapy because: _____

I usually feel (check all that apply):

- | | | | |
|-----------------------------------|---------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Happy | <input type="checkbox"/> Depressed | <input type="checkbox"/> Anxious | <input type="checkbox"/> Panicky |
| <input type="checkbox"/> Calm | <input type="checkbox"/> Confused | <input type="checkbox"/> Scared | <input type="checkbox"/> Excited |
| <input type="checkbox"/> Lost | <input type="checkbox"/> Alone | <input type="checkbox"/> Empty | <input type="checkbox"/> Hopeless |
| <input type="checkbox"/> Helpless | <input type="checkbox"/> Other: _____ | | |

I have heard things that others cannot hear: No Yes Please describe: _____

I have seen things that others cannot see: No Yes Please describe: _____

I have felt things that others cannot feel: No Yes Please describe: _____

My appearance is usually: _____

I usually feel _____ about myself.

I have friends: No Yes # _____ Males # _____ Females

Name: _____ Date: _____

When I am with my friends I: _____

I have a girlfriend boyfriend N/A

I feel I am heterosexual I feel I am homosexual I feel I am other: _____

I am or have been sexually active: Yes No

I have practiced safe sex: N/A Yes, type of contraceptive: _____
_____ No because: _____

Name of school: _____ N/A

I like school: N/A Yes No because: _____

My grades are usually (check all that apply): A B C D F

My in school conduct is usually: _____

My favorite subjects are: N/A _____

My least favorite subjects are: N/A _____

In school/at work I have trouble with (check all that apply): N/A

Memory Attention/Concentration Understanding some subjects
(Which ones: _____)

Other: _____

Sometimes I get into fights: No Yes because: _____

I am employed by: _____ N/A

My job title is: _____ N/A

I enjoy my job: Yes No I have been employed for (time): _____ N/A

Military experience (i.e., branch, type of discharge, etc.): _____ N/A

For fun I like to: _____

Name: _____ Date: _____

I live with: _____

I get along with my siblings: N/A Yes No because: _____

I get along with my parents (or other caregivers): N/A Yes No because: _____

I usually get along with adults: Yes No because: _____

I usually get along with children: Yes No because: _____

I have used the following types of alcohol/illegal substances: put a * by your drug of choice

Name of drug	Age of first use	Amount/Frequency	Date of last use

I sleep okay: Yes No because: _____

I have a good appetite: Yes No because: _____

I have been involvement with the Legal System: No Yes because: _____

I have been emotionally abused, physically abused, sexually abused, or
 abandoned N/A

I wish I could: _____

I have the following medical problems: _____

Name: _____ Date: _____

I take the following prescription or over the counter medications:

Name of medicine	Why?

Use additional space at bottom/back of this page if needed.

Type of discipline used in my home: _____ N/A

When I get upset I: _____
_____ to help me calm down.

I have cut, burn, scratched or hurt myself: No Yes because: _____

Types of Coping Skills (e.g., reading, writing, meditating, self-injury) I use: _____

I have tried to kill myself before: No Yes because: _____

How? _____

I have thought about killing someone else: No Yes because: _____

I have had previous treatment (e.g., in-patient, private therapist, residential treatment):
 No Yes because: _____

I am willing to receive therapy: No because: _____ Yes because: _____

Others things that are important for you to know about me: _____

Additional space if needed: _____

