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INITIAL CONSULTATION QUESTIONNAIRE

Please fill out this form and bring it to your first session. Parents of teenagers are encouraged to fill out the form with your child. Specific questions for teenagers and parents are on pages 5-6

Date of Initial Appointment: _____

Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street and Number) (City) (State) (Zip)

Birth Date: ____ / ____ / ____ Age: _____ Gender: Male Female Non-binary
 Transgender

Cell/Other Phone: (_____) May I leave a message? Yes No

Home Phone: (_____) May I leave a message? Yes No

E-mail: _____ May I email you? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Name of parent/guardian (if under 18 years):

(Last) (First) (Middle Initial)

Marital Status:

Never Married Married Partnered Living Together Separated
 Divorced Widowed

Please list any children/age: _____

Education: Less than High School High School or GED Some College College
 Graduate Post Grad

Race: African American Caucasian Asian Hispanic Multicultural Other: _____

REASON FOR REFERRAL (How can I help?):

MENTAL HEALTH INFORMATION

Have you previously received any type of behavioral health services?

No Yes, previous therapist/practitioners: _____

Have your problems interfered with your ability to function with your work, school or relationships?

Yes No

If Yes, please describe _____

In the past 2 weeks, have you been bothered by feeling down, depressed or hopeless?

Yes No

In the past 2 weeks, have you been bothered by little interest or pleasure in doing things?

Yes No

In the past 2 weeks, have you been bothered by trouble falling or staying asleep, or sleeping too much? Yes No

Have you had any significant changes in your appetite or weight?

Yes No If Yes, please describe _____

Are you currently having any thoughts of harming yourself or anyone else?

Yes No

Have you had any thoughts of harming yourself or another in the past?

Yes No

Have you ever heard or seen things that other people couldn't hear or see?

Yes No

Are you experiencing anxiety that interferes with your normal activities?

Yes Does this include panic attacks or phobias?

When did these begin? _____

No

Have you ever been bothered by recurrent thoughts or impulses that were unwanted, inappropriate, intrusive or distressing? Yes No

Have you ever been prescribed psychiatric medication? Yes No

If Yes, please list and provide dates:

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:

	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	

GENERAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

Please list your Primary Care/Family Physician:

(Name)	(Address)	(Phone #)

2. Are you currently taking any prescription medication? Yes No

If Yes, please list:

3. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

4. How many times per week do you generally exercise? _____

What types of exercise to you participate in _____

5. Please list any difficulties you experience with your appetite or eating patterns

6. Are you currently experiencing any chronic pain? No Yes

If yes, please describe _____

7. Do you drink alcohol more than once a week? Yes No

8. Have you ever drunk or used drugs more than you meant to? Yes No

9. Have you felt you wanted or needed to cut down on your drinking or drug use?

Yes No

10. How often do you engage recreational drug use? Daily Weekly Monthly

Infrequently Never

11. Do you smoke cigarettes? No Yes How many cigarettes/day? _____

12. Are you currently in a romantic relationship? No Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

13. Do you have any legal problems currently? No Yes

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

ADDITIONAL INFORMATION:

1. Are you currently employed? No Yes

If Yes, what is your current employment situation:

If Yes, do you enjoy your work? Is there anything stressful about your current work?

2. Do you consider yourself to be spiritual or religious? No Yes

If yes, describe your faith or belief:

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weaknesses?

5. What would you like to accomplish out of your time in therapy?

ADOLESCENT QUESTIONS

QUESTIONS FOR PARENTS:

1. How has the referring problem had an impact on the way your child has been functioning in school or with friends?

2. What type of behavioral problems has your child experienced?

Does not listen to authority Aggression Cruelty Stealing
 Running Away Academic Other: _____

Please describe:

ADOLESCENT QUESTIONS, continued

3. Has you your child ever been evaluated for ADD/ADHD or learning problems?

Yes No If yes, when? _____

Please summarize results and recommendations:

4. Are you aware of your child drinking alcohol or using drugs?

Yes No

If Yes, please explain:

QUESTIONS FOR ADOLESCENTS:

1. Please list 3 or 4 activities that you enjoy doing either alone or with friends:

2. What types of music do you like to listen to? What are your favorite musical groups?

3. Please list several things that your friends would say they like about you:

4. Are there things worry or trouble you that YOU feel are important for me to know about?

No Yes

If Yes, please describe:
