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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 <u>in the past</u>?
□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:

_____

_____