# PSYCHOTHERAPY HISTORY QUESTIONNAIRE


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**Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the first session.**

**NAME: _____ GENDER: _____ DATE :_____**

**DATE OF BIRTH/PLACE: _____ AGE: _____**

**ADDRESS: _____**

**TELEPHONE: Home:_____Mobile: _____**

**HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____**

**EMERGENCY CONTACT PERSON NAME & PHONE NUMBER:**

_____

**REFERRAL SOURCE: _____**

**OCCUPATION** (former, if retired): _____

**PRESENTING PROBLEM** (be as specific as you can: when did it start, how does it affect you.):

_____

_____

_____

_____

_____

_____

**Estimate the severity of above problem:** ___Mild ___Moderate ___Severe ___Very Severe

**SYMPTOMS:** **Check all that apply to you in the past 6 months**

| Check | | Rate How Severe: Mild | Moderate | Severe | Date of Onset |
|---|---|---|---|---|---|
| | **Sadness or depression** | | | | |
| | **Anxiety or nervousness** | | | | |
| | **Stress** | | | | |
| | **Sleeping problems: (Falling Asleep ___ Staying Asleep ___)** | | | | |
| | **Become more angry easily** | | | | |
| | **Euphoria (feeling on top of the world)** | | | | |
| | **Much more emotional (e.g., cry more easily)** | | | | |
| | **Feel as if I just don't care anymore** | | | | |
| | **Doing things automatically (without awareness)** | | | | |
| | **Less inhibited (to do things I would not do before)** | | | | |
| | **Difficulty being spontaneous** | | | | |
| | **Change in eating habits:** | | | | |
| | **Change in interest in sex:** | | | | |
| | **Loss of energy** | | | | |
| | **Increase of energy** | | | | |
| | **Experiencing nightmares on a daily/weekly basis** | | | | |
| | **Loss of sexual desire** | | | | |
| | **Increase in weight_____ Loss of weight_____** | | | | |
| | **Lack of interest in pleasurable activities** | | | | |
| | **Increase in irritability** | | | | |
| | **Increase in aggression** | | | | |
| | **Other recent changes in behavior or personality:** | | | | |

**CURRENT: Marital/Partnered status:_____ Live with someone:_____**

**Name:_____Years:_____**

**PAST & PRESENT Marriage/s or Partnership/s** (years together, names & brief statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile):_____

_____

_____

_____

**PRESENT SPOUSE/PARTNER:** _____

**Education:** _____ **Occupation:** _____

**CHILDREN/STEP/GRAND** (names/ages & brief statement regarding your relationship)

**1.**_____

**2.**_____

**3.**_____

**4.**_____

**5.**_____

**PARENTS/STEP-PARENTS** (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship):

**Father:**_____

_____

_____

_____

**Mother:**_____

_____

_____

_____

**Step-parents**_____

_____

_____

_____

**SIBLINGS** (name, age and/or cause of death & brief statement about the relationship):

**1.**_____

**2.**_____

**3.**_____

**4.**_____

**5.**_____

**How many biological family members do you have who live in the same city/state, which relatives are they, and how often do you see them?**

_____

_____

**CURRENT PSYCHIATRIST (IF APPLICABLE)** (name /phone):

_____

**PRIMARY CARE PHYSICIAN** (name/phone):

_____

**PAST/PRESENT MEDICAL CARE** (major medical problems, surgeries, accidents, falls, illness):

_____

_____

_____

_____

**SPECIFY ALL MEDICATIONS you are presently taking, WHAT YOU ARE TAKING THEM FOR, and the PRESCRIBING PHYSICIAN FOR EACH. Please PRINT clearly:**

_____

_____

_____

_____

_____

_____

_____

**How often do you drink alcohol? (# times per week or month):** _____

**How many drinks do you have when you drink and what type of drinks do you have?**

_____

**What kind of recreational drugs do you take and how often do you take them?**

_____

**Do you ever take prescription drugs in ways they have not been prescribed? (e.g., taking more than prescribed dosage) and if so, which drugs?**_____

_____

**PAST/PRESENT DRUG/ALCOHOL ABUSE** (AA, NA, time sober/clean, treatments, rehab?)**:**

_____

_____

**SUICIDE ATTEMPT/S** or **VIOLENT BEHAVIOR** (describe: ages, reasons, circumstances, how, etc)_____

_____

**FAMILY MEDICAL HISTORY** [Describe any <u>illness</u> that runs in the family - which relatives? Which illnesses? (e.g., multiple sclerosis, cancer, epilepsy, Alzheimer's disease, etc)

_____

_____

_____

_____

**How many FRIENDS do you have <u>with whom you socialize regularly</u> and <u>how often do you see them</u>?**_____

_____

**How many FRIENDS do you have whom you feel <u>you can count on for support</u>, and which friends are they?**_____

_____

**Are you involved in any COMMUNITY activities? If so, <u>which activities</u>, and <u>how often</u>?**

_____

_____

**Are you involved in any SPIRITUAL or RELIGIOUS activities? If so, which activities, and how often? <u>And/or</u> – how would you describe your Spirituality and/or Religion?**

_____

_____

_____

**PAST/PRESENT PSYCHOTHERAPY:** Please specify: How long you were in therapy each time? Approximate dates of therapy (beginning/end)? Estimated # of sessions? Therapist name, and therapist's degree? Initial reason for therapy? Was it Individual, Couple, or Family therapy? What kind of therapy was it (e.g., Psychodynamic, CBT, not sure, etc)? Briefly describe the relationship with therapist? How helpful was therapy? How/why did the therapy end?

_____

_____

_____

_____

_____

_____

_____

_____

*<u>USE OTHER SIDE OF THE PAGE FOR MORE INFORMATION ABOUT PSYCHOTHERAPISTS</u>*

**DESCRIBE YOUR CHILDHOOD IN GENERAL** (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

_____

_____

_____

_____

_____

_____

_____

**IF PARENTS DIVORCED:** Your age at the time: _____, Describe how it affected you at the time:_____

_____

_____

**FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS OR VIOLENCE** (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

_____

_____

**ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S?** (if you answer Yes, please explain): _____

_____

**What gives you the most joy or pleasure in your life?**

_____

_____

**What are your main worries and fears?**

_____

_____

**What are your most important hopes or dreams?**

_____

_____

_____

**Please add <u>any other information you would like me to know</u> about you and your situation below:**