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Assessment Questionnaire

Print Name:	Date of Birth:

Primary reason(s) why you're seeking help?

1. _____
2. _____
3. _____

Current and Past Medical History

Allergies (medication/allergen and reaction): _____

List **ALL** current medications, herbs, supplements, over-the-counter medications: (use additional paper if needed)

Name	Dose	How often it's taken

List any psychiatric medications tried in the past: _____

Write YES next to any **CURRENT** or **PAST** medical conditions and explain if needed:

Condition	**YES / Explain**	**Condition**	**YES / Explain**
Thyroid Disease		Vitamin Deficiency	
Liver Disease		Epilepsy/Seizures	
Kidney Disease		Migraines	
Diabetes		Head Trauma/Concussion	
Cancer		Heart Disease	
Asthma		High Cholesterol	
COPD		High Blood Pressure	
Fibromyalgia		Irritable Bowel Syndrome	
Chronic Fatigue		HIV	
Chronic Pain		Anemia	
Hepatitis C		Other	

List any past surgeries or non-mental health hospitalizations: _____

How would you rate your current physical health - poor ◯ satisfactory ◯ good ◯ very good ◯ excellent ◯

List any specific health problems you're currently having: _____

How would you rate your sleep - poor ◯ satisfactory ◯ good ◯ very good ◯ excellent ◯

Describe any sleep problems you're currently having: _____

How many times a week, if any, do you exercise? _____ What do you? _____

Please describe any challenges you have with food: _____

Name: _____
D.O.B.: _____

Developmental History

Did you have any developmental delays in early childhood (crawling, walking, talking, toileting, etc. Yes ☐ No ☐
If yes, please explain: _____
When your mother was pregnant with you were there any complications during the pregnancy or birth? Yes ☐ No ☐
If yes, please explain: _____
Did your mother use any drugs, tobacco, or alcohol when she was pregnant with you? Yes ☐ No ☐
If yes, please explain: _____

Mental Health and Substance Use Treatment History (use back of paper if needed)

Yes	No	Type of Treatment	When	Provider/Program	Reason for treatment
		Outpatient Counseling			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-Help/Support Group			

Have **you, or anyone in your family**, been diagnosed with or treated for:

Condition	Who	Condition	Who
Anxiety		Post-Traumatic Stress	
Depression		Schizophrenia	
OCD		Substance Abuse	
Bipolar Disorder		Suicide Attempt	
Personality Disorder(s)		ADHD/ADD	
Eating Disorder(s)		Other –please explain	

Substance Use

Substance	How Much	How Often	Age First Used	Last Use
Tobacco				
Alcohol				
Marijuana				
Methamphetamine				
Cocaine				
Stimulant Pills				
Pain Pills *				
Tranquilizer/Sleep Pills*				
LSD				
PCP				
Ecstasy				
Heroin				
Other				

* = non-prescribed or more than prescribed

How many caffeinated drinks per day? Coffee ____ Tea _____ Pop_____ Energy Drinks _____ Other _____

Past/Current Behavioral Addictions

Behavior	How Often?	Current or Past Concern?
Gambling		
Pornography/Sexual		
Internet/Video Games		
Other, please explain		

Name:_____
D.O.B.:_____

Have you ever tried to harm yourself? Yes ☐ No ☐ Have you ever tried to harm anyone else? Yes ☐ No ☐

Religion

Are religious/spiritual issues important in your life? Yes ☐ No ☐

Family Background and Childhood History

Were you adopted? Yes ☐ No ☐ Where did you grow up?_____

Who raised you primarily?_____ Are your parents still alive? Yes ☐ No ☐

List your siblings and their ages:_____

Mother/Father/Guardian occupations: _____

Did your parents marry? Yes ☐ No ☐ Did they separate? Yes ☐ No ☐ If so, what age were you when they separated?___

Trauma History

Were you ever physically, sexually, or emotionally abused or neglected or did you witness abuse? Yes ☐ No ☐ Not Sure ☐

Have you experienced any other kind of significant trauma? Yes ☐ No ☐ Not Sure ☐

If yes, please describe (or you may wait to discuss with your therapist instead)_____

_____

Do you feel safe now? Yes ☐ No ☐

Education History

Highest level of education attained:_____

Any extra help provided in school (IEP, 504, Special Education, etc.)? Yes ☐ No ☐

Occupational History

Are you currently working, a student, unemployed, stay at home parent, disabled, retired, or other_____

What is/was/will be your occupation?_____ For how long_____

Where do you work?_____

Have you ever served in the military? Yes ☐ No ☐ If yes, what branch and when?_____

Relationship History and Current Family

Are you currently married, single, divorced, partnered, dating, widowed, or other? _____

Sexual Orientation: _____ If you're in a relationship, for how long? _____

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

What is your significant other's occupation?_____

Have you had any prior marriages? Yes ☐ No ☐ If yes, how many?_____

List any children/dependents, their ages, and genders:_____

List everyone who currently lives with you:_____

Legal History

Have you ever been arrested? Yes ☐ No ☐ If yes, for what?_____

Do you have any pending legal charges? Yes ☐ No ☐ Are you involved in a divorce or other legal proceedings? Yes ☐ No ☐

Treatment Planning

What are your strengths?_____

_____

What do you struggle with? _____

_____

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

_____

What would you like to accomplish in therapy? _____

_____

Do you have anything else to add? _____