

CONFIDENTIAL QUESTIONNAIRE

FILL OUT THE INFORMATION THAT APPLIES TO YOU. LEAVE BLANK ANY QUESTIONS THAT YOU DO NOT FEEL COMFORTABLE ANSWERING OR THAT DO NOT APPLY.

TODAY'S DATE _____

NAME _____ AGE _____

ADDRESS _____ CITY _____ ZIP _____

HOME PHONE _____ ALTERNATE PHONE _____

DATE OF BIRTH _____ PLACE OF BIRTH _____

NUMBER OF BROTHERS _____ NUMBER OF SISTERS _____ YOU ARE THE _____ CHILD.

HIGHEST LEVEL OF EDUCATION _____

MENTAL HEALTH/PSYCHOLOGY COURSEWORK _____

RELIGIOUS PREFERENCE: NOW: _____ IN CHILDHOOD: _____

EMPLOYER _____ POSITION _____

SINGLE LIVING TOGETHER MARRIED PARTNERED HOW LONG _____

ENGAGED SEPARATED DIVORCED WIDOWED

NUMBER OF PREVIOUS MARRIAGES _____ FIRST NAMES OF PREVIOUS MATES, NUMBER OF YEARS

TOGETHER AND NUMBER OF CHILDREN BORN TO THAT RELATIONSHIP _____

MOTHER'S OCCUPATION _____ HER AGE _____ AGE AT DEATH _____

CAUSE OF DEATH _____

FATHER'S OCCUPATION _____ HIS AGE _____ AGE AT DEATH _____

CAUSE OF DEATH _____

HOW WOULD YOU RATE YOUR PARENTS MARRIAGE? VERY HAPPY HAPPY AVG UNHAPPY

IF DIVORCED, WHAT WAS YOUR AGE WHEN THIS OCCURRED? _____

YOU WERE REFERRED BY: SELF OTHER _____

YOUR CHILDREN: LIST NAME, AGE, SEX, COMMENTS (CUSTODY, SUPPORT, ETC)

YOUR PRESENT HEALTH

EXCELLENT AVERAGE POOR DATE OF LAST PHYSICAL: _____

FINDINGS _____

ARE YOU PRESENTLY ON ANY MEDICATIONS? YES NO IF YES, WHAT KIND, FOR WHAT?

NAME OF PRIMARY CARE PHYSICIAN _____ PHONE _____

LIST PREVIOUS PSYCHOTHERAPY, COUNSELING, OR PERSONAL/MARITAL TREATMENT; ALSO LIST IF YOU HAVE EVER BEEN DIAGNOSED WITH A MENTAL HEALTH OR SUBSTANCE ABUSE DISORDER:

DATE *TYPE OF PROBLEM* *NAME OF PRACTITIONER OR AGENCY*

HAVE YOU EVER BEEN HOSPITALIZED FOR PSYCHIATRIC CARE? YES NO

IF YES, WHEN, WHERE, FOR WHAT?

ANY OTHER INFORMATION THAT COULD HELP THE THERAPIST NOT OTHERWISE INCLUDED HERE?

