Dr. Beau A. Nelson, DBH, LCSW
Doctor of Behavioral Health
12830 Hillcrest Road, Suite D235
Dallas, Texas 75230
972-980-9911

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 _____

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 ___ Average ___ 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 ___ Fair ___ 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 to get know you and your situation?

_____

_____

_____

_____

_____

_____

_____

_____

Personal Health History

Please check which of the following you have had:

Condition	Yes	Date	Condition	Yes	Date
Asthma			Paralysis		
Tuberculosis			Shaking		
Pneumonia			Impotence		
Hemorrhoids			Miscarriage		
Meningitis			Menstrual trouble		
Bad headaches			Nerve trouble		
High blood pressure			Ulcer		
Low blood pressure			Discouragement		
Constipation			Worries		
Diarrhea			Depression		
Diabetes			Tension		
Thyroid trouble			Irritableness		
Tumors			Alcoholism		
Cancer			Insomnia		
Accident (serious)			Hysterectomy		
Sterility			Appetite loss		
Surgery (major)			Vasectomy		
Fainting			Sexually unresponsive		
Convulsions			Heart trouble		
Hearing problems			Other		
Back trouble			Other		

Any current legal issues? _____

Any past legal issues? _____

Have you ever filed a complaint against a professional? If yes, please explain:

_____

Do you have thoughts of self harm? Yes ___ No ___ If yes, explain _____

Any thoughts of harming someone else? Yes ___ No ___ If yes, explain _____

Please circle a number for each below, if it does not apply leave blank:

Concern	***Very Dissatisfied***					***to***				***Very Satisfied***
Household responsibilities	1	2	3	4	5	6	7	8	9	10
Children	1	2	3	4	5	6	7	8	9	10
Sex	1	2	3	4	5	6	7	8	9	10
Social activities	1	2	3	4	5	6	7	8	9	10
Money	1	2	3	4	5	6	7	8	9	10
Communication	1	2	3	4	5	6	7	8	9	10
Sexual identity	1	2	3	4	5	6	7	8	9	10
Independence/dependence	1	2	3	4	5	6	7	8	9	10
Partner	1	2	3	4	5	6	7	8	9	10
Relatives	1	2	3	4	5	6	7	8	9	10
Spirituality	1	2	3	4	5	6	7	8	9	10
Alcohol	1	2	3	4	5	6	7	8	9	10
Non-prescription drugs	1	2	3	4	5	6	7	8	9	10
Jealousy	1	2	3	4	5	6	7	8	9	10
Infidelity	1	2	3	4	5	6	7	8	9	10
Career/work	1	2	3	4	5	6	7	8	9	10
Physical health	1	2	3	4	5	6	7	8	9	10