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General Information Questionnaire

Your cooperation in completing this questionnaire will be helpful in planning our work together. All information is kept confidential. Please answer each item or ask me for clarification if you do not understand an item. Thank you.

Today's Date: _____

Client's Full Name: _____ Age: _____

Date of Birth: _____ Gender: M ___ F ___ SS#: _____ (optional)

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address: _____

Occupation: _____ Employer: _____

Education Completed/Training/Military Status: _____

Religious Affiliation: _____

If a Student: School/ College: _____ Grade Level: _____

Relationship Status: Single ___; Married ___ Years ___; Widowed ___

Divorced ___ Times ___ Years since divorce ___

Living with partner ___ Years ___

Spouse or Partner Name: _____ Age: _____

Who referred you? _____ May I thank him/her? _____

May I contact you at work? _____ At home? _____

May I leave messages for you at work? _____ At Home? _____

Persons to Contact in case of Emergency

Name: _____ Phone: _____

Name: _____ Phone: _____

Insurance: If you plan to use insurance to cover all or part of your visit here, please complete the following information: **Be sure to fill out the information for the policy holder.**

Insurance Company: _____

Policy Holder(name): _____ **Birth Date:** _____

SS#: _____ **Policy Holder Employer:** _____

Policy Holder Address: _____ **City/State/Zip:** _____

Policy Holder Phone: _____

Deductible:\$ _____ **met** _____ **unmet** _____ ; **Co-pay** \$ _____

Group Number: _____ **Policy Number:** _____

Please sign giving permission for Insurance Co. payment of services:

_____ **Date:** _____

(Signature of Responsible Party)

Health Information:

Family Physician: _____ **Date of last visit:** _____

Please rate your physical health: Very good: _____ Good: _____ Average: _____ Declining: _____

List all important present or past illnesses or injuries causing handicaps: _____

Current Medications prescription and non- prescription: _____

Briefly describe your reason for seeking help: _____

Have you ever received psychiatric, psychological help or counseling of any kind before? _____

If Yes, with whom, where and the reason?: _____

List the members of your family and all others in your home:

Name(s)	Age	Relationship	Occupation
_____	_____	_____	_____
_____	_____	_____	_____

Please circle any of the following problems which pertain to you:

- | | | | |
|------------------|------------------|------------------|-----------------|
| Nervousness | Aggressive | Guilt | Parents |
| Anxiety | Behavior | Jealous Feelings | Muscle Tension |
| Finances | Loss of Control | Menstrual Prob. | Health Problems |
| Self Control | Suspicious of | Stress | Hypochondriasis |
| Temper Outbursts | Others | Children | Bowel Problems |
| Anger | Hearing Problems | Being a Parent | Stomach Trouble |

Weight Loss/Gain
Appetite
Eating Pattern
Binging
Vomiting
Purging
Depression
Loss of Interests
Tiredness
Energy
Self Worth
Inferiority
Feelings
Memory
Concentration
Hearing Things
Purpose in Life
Suicidal Thoughts
Suicidal Behavior
Risk Taking

Drug Use
Alcohol Use
Self-Control
Unhappiness
Relaxation
Fear
Phobic Avoidance
DUI?
Compulsions
Nervous Tics
Making Decisions
Education
Sleep Problems
Insomnia
Nightmares
Withdrawal
Fitting In
Friends
Shyness
Loneliness

Boredom
Relationships
Sexual Problems
Physical Contact
Being Touched
Shame
Separation
Divorce
Marriage
Career Choices
Making Decisions
Work
Legal Matters
Abuse
Flashbacks
Visual
Disturbance
Time Loss
My thoughts
My Beliefs

Odd Behavior
Feeling Out of
Body
Feeling Unreal
Hallucinations
Delusions
Headaches
Chest Pains
Palpitations
Dizziness
Excessive
Sweating
Pain
Hurting Self
Ambition
Other: _____

