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Assessment Questionnaire

Print Name:	Date of Birth:

Primary Reason(s) Why You're Coming to Therapy
1.____
2.____
3.____

Current and Past Medical History

Allergies (medication/allergen and reaction):____

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

Name	Dose	How often it's taken

List any psychiatric medications tried in the past:____

Circle any current or past medical conditions and explain if needed

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

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

How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very Good Excellent
List any specific health problems you're currently having:____

How would you rate your sleep? (please circle)
Poor Unsatisfactory Satisfactory Good Very Good Excellent
List any sleep problems you're currently having: ____

How many times a week, if at all, do you exercise? ________ What do you do? ______________________________

Please describe any challenges you have/had with food: ____

Developmental History

Did you have any developmental delays in early childhood (crawling, walking, talking, toileting, etc..)? YES/NO

If yes, explain:____

When your mother was pregnant with you, were there any complications during the pregnancy or birth? YES/NO

If yes, explain:____

Did your mother user any drugs, tobacco, or alcohol when she was pregnant with you? YES/NO

If yes, explain:____

Mental Health 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
Bipolar Disorder		Post-traumatic Stress	
Depression		Schizophrenia	
Anxiety / OCD		Substance Abuse	
ADD/ADHD		Suicide Attempt	
Personality Disorder		Other	

Substance Use

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

How many caffeinated drinks per day? Coffee_______ Tea________ Soda_______ Energy Drinks__________

Family Background and Childhood History
Were you adopted? YES/NO Where did you grow up?____
Who raised you primarily?_____________________ Are your parents still alive? _________________________
List your siblings and their ages:____
Mother/Father/Guardian occupations:____
Did your parents separate? YES/NO If so, what age were you when they separated?_________________

Trauma History
Do you have any history of being physically, sexually, emotionally abused or neglected? YES/NO
If yes, please describe who and when (or you may wait to discuss with provider instead)____________________
____
____

Education History
Highest level of education attained:____
Any extra help provided in school (IEP, 504, Special Education, etc.)?____________________________________

Occupational History
Are you currently (circle): Working Student Unemployed Stay at Home Parent Disabled Retired Other
What is/was 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 (circle): Married Single Divorced Partnered Dating Widowed Other
Sexual Orientation: ____________________ If you're in a relationship, for how long? ________________
Have you had any prior marriages? YES/NO Is yes, how many?______
On a scale of 1-10, how would you rate your relationship? _______
What is your significant other's occupation?_________________________________
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 currently involved in any divorce or 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?
____