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New Patient Questionnaire

All information provided is strictly confidential and released only with your written permission.

Patient's Name: ____

Today's Date: ____________

Name and relationship of person filling out this form (if other than patient):

____

Please summarize the circumstances that led to seeking this appointment.

1. ____
   ____
   ____

2. ____
   ____
   ____

3. ____
   ____

4. ____
   ____

When did they first appear? ____

____

Did a specific event lead to this appointment: Yes_____ No_____

If yes, what was the event? ____

____

Have you ever been exposed to a traumatic or especially stressful event including sexual, emotional or physical abuse? If yes, please describe in a few words.

____

____

Past Psychiatric History:

Are you currently in treatment with a psychologist, psychiatrist or other therapist? Yes__ No__

Have you ever been in counseling before? Yes__ No__

Have you ever been hospitalized for psychiatric reasons? Yes___ No___

If Yes, what reasons? ____

Have you ever attempted suicide? Yes___ No___

If Yes, how and when?____

Do you currently self-harm? Yes___ No____ If you do, what is your method?

____

Please list any medications that you take for **mental health reasons**:

____

Social History:

Who lives in the home? ____

____

Is there significant conflict at home? Yes___ No___

If Yes, please describe: ____

____

Relationships:

Who is an important source of support for you? _______________________________________

____

Are you married? Yes___ No___ If Yes, how long? __________________

If divorced, what was the reason for prior separation/divorce: ___________________________

____

Legal History:

Any previous or ongoing legal issues? Yes___ No___

____

Expectations from Treatment:

What are you hoping for from this evaluation?

What would you not want from the treatment?

Psychotherapy Goals:

1.

2.

3.