FOOTHILL PSYCHOLOGICAL ASSOCIATES

PATIENT QUESTIONNAIRE

PATIENT

First Name: _____ Middle Name: _____ Last Name: _____

Preferred Name: _____ DOB: _____ SS#: _____ Living Arrangement: _____

Occupation: _____ Highest Level of Education: _____

Religion/Spirituality: _____

_____

_____

May I send mail to your home address? ☐ Yes ☐ No
May I leave a detailed message on your home phone? ☐ Yes ☐ No
May I leave a detailed message on your work phone? ☐ Yes ☐ No
May I leave a detailed message on your mobile phone? ☐ Yes ☐ No
May I send you text messages? ☐ Yes ☐ No

Contact person in case of emergency: _____ Relationship: _____ Phone #:_____

FAMILY OF ORIGIN (*adult patients only*)

Place of birth _____

Those you lived with growing up:

Relationship to you: _____ Name: _____ Age: _____ Occupation: _____

Relationship to you: _____ Name: _____ Age: _____ Occupation: _____

Relationship to you: _____ Name: _____ Age: _____ Occupation: _____

Relationship to you: _____ Name: _____ Age: _____ Occupation: _____

Relationship to you: _____ Name: _____ Age: _____ Occupation: _____

Relationship to you: _____ Name: _____ Age: _____ Occupation: _____

Relationship to you: _____ Name: _____ Age: _____ Occupation: _____

Relationship to you: _____ Name: _____ Age: _____ Occupation: _____

NUCLEAR FAMILY/ FAMILY OF PROCREATION

Names of others presently living at home:

Relationship to you: _____ Name: _____ Age: _____ Occupation: _____

Relationship to you: _____ Name: _____ Age: _____ Occupation: _____

Relationship to you: _____ Name: _____ Age: _____ Occupation: _____

Relationship to you: _____ Name: _____ Age: _____ Occupation: _____

Relationship to you: _____ Name: _____ Age: _____ Occupation: _____

Relationship to you: _____ Name: _____ Age: _____ Occupation: _____

Relationship to you: _____ Name: _____ Age: _____ Occupation: _____

Relationship to you: _____ Name: _____ Age: _____ Occupation: _____

PATIENT HEALTH HISTORY

Primary Care Physician: _____ Date of Last Exam: _____

Current Medical Condition(s): _____

Any peri-natal or developmental abnormalities? ☐ No ☐ Yes If yes, please explain: _____

Are you currently taking any prescription or "over the counter" medication(s)? ☐ No ☐ Yes

If Yes, please identify the name, current dosage, and date began for each: _____

Do you have any allergies? ☐ No ☐ Yes If yes, please list: _____

Have you received any psychotherapy/counselling treatment before? ☐ No ☐ Yes Your age at the first visit? _____

1. From: _____ through _____ Therapist: _____
2. From: _____ through _____ Therapist: _____
3. From: _____ through _____ Therapist: _____

Are you currently under the care of a psychiatrist? ☐ No ☐ Yes If Yes, Name: _____

M.D. Tel._____

Have you <u>previously</u> received any psychiatric medication? ☐ No ☐ Yes

1. Med name: _____ Dosage: _____ Rx date: _____ Prescriber: _____
2. Med name: _____ Dosage: _____ Rx date: _____ Prescriber: _____
3. Med name: _____ Dosage: _____ Rx date: _____ Prescriber: _____
4. Med name: _____ Dosage: _____ Rx date: _____ Prescriber: _____
5. Med name: _____ Dosage: _____ Rx date: _____ Prescriber: _____

Are you <u>currently</u> prescribed psychiatric medication? ☐ No ☐ Yes

1. Med name: _____ Dosage: _____ Rx date: _____ Prescriber: _____
2. Med name: _____ Dosage: _____ Rx date: _____ Prescriber: _____
3. Med name: _____ Dosage: _____ Rx date: _____ Prescriber: _____
4. Med name: _____ Dosage: _____ Rx date: _____ Prescriber: _____
5. Med name: _____ Dosage: _____ Rx date: _____ Prescriber: _____

Have you had any inpatient/hospital treatment for mental health or substance abuse? ☐ No ☐ Yes If yes, please list:

Hospital (s)	Address	Date of Hospitalization

Do you smoke cigarettes? ☐ No ☐ Yes If yes, how many per day? _____

How much alcohol do you drink per week on average? _____ drinks per week

Have you had problems with your drinking (legal, health, work, relationship?)

☐ No ☐ Yes If Yes, please explain: _____

Family History: Please indicated which of the following is true for yourself and other family members?

	Self	Mother	Father	Siblings	Grandparents
Depression	☐	☐	☐	☐	☐
Suicide Attempts	☐	☐	☐	☐	☐
Alcohol Problems	☐	☐	☐	☐	☐
Drug Problem	☐	☐	☐	☐	☐
Mental Problems	☐	☐	☐	☐	☐

Medical History: Please check all of the following, which you now have or have had in the past:

- ☐ Heart Trouble
- ☐ Frequent/severe *headaches*
- ☐ Head Injury
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Fainting/Dizziness
- ☐ Stroke
- ☐ Shortness of Breath
- ☐ Stomach Problems
- ☐ Kidney Trouble
- ☐ Bedwetting/Soiling
- ☐ Epilepsy/Convulsions
- ☐ Back Problems
- ☐ Unusual Bleeding
- ☐ Asthma/Hay Fever
- ☐ Arthritis
- ☐ Sleep Difficulties
- ☐ Mood Change

Any other serious illness(es): _____

_____

_____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues."

- ☐ I have no problem or concern bringing me here
- ☐ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Career concerns, goals, and choices
- ☐ Childhood issues (your own childhood)
- ☐ Codependence
- ☐ Confusion
- ☐ Compulsions
- ☐ Custody of children
- ☐ Decision making, indecision, mixed feelings, putting off decisions
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce, separation
- ☐ Drug use—prescription medications, over-the-counter medications, street drugs
- ☐ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Financial or money troubles, debt, impulsive spending, low income
- ☐ Friendships
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Guilt
- ☐ Headaches, other kinds of pains
- ☐ Health, illness, medical concerns, physical problems
- ☐ Housework/chores—quality, schedules, sharing duties
- ☐ Inferiority feelings
- ☐ Interpersonal conflicts
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Judgment problems, risk taking
- ☐ Legal matters, charges, suits
- ☐ Loneliness

- ☐ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ☐ Memory problems
- ☐ Menstrual problems, PMS, menopause
- ☐ Mood swings
- ☐ Motivation, laziness
- ☐ Nervousness, tension
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Oversensitivity to rejection
- ☐ Panic or anxiety attacks
- ☐ Parenting, child management, single parenthood
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Procrastination, work inhibitions, laziness
- ☐ Relationship problems (with friends, with relatives, or at work)
- ☐ School problems (see also "Career concerns . . . ")
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-neglect, poor self-care
- ☐ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- ☐ Shyness, oversensitivity to criticism
- ☐ Sleep problems—too much
- ☐ Sleep problems—too little
- ☐ Sleep problems—insomnia
- ☐ Sleep problems—nightmares
- ☐ Smoking and tobacco use
- ☐ Spiritual, religious, moral, ethical issues
- ☐ Stress, relaxation, stress management, stress disorders, tension
- ☐ Suspiciousness
- ☐ Suicidal thoughts
- ☐ Temper problems, self-control, low frustration tolerance
- ☐ Thought disorganization and confusion
- ☐ Threats, violence
- ☐ Weight and diet issues
- ☐ Withdrawal, isolating
- ☐ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition

Any other concerns or issues:

☐ _____

☐ _____

☐ _____

☐ _____

Please look back over the concerns you have checked off and choose the one that you most want help with.

It is: _____

_____

_____

_____

Please write a brief statement of your current problem/s: _____

_____

_____

_____

_____