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History Questionnaire

Your Name: ____ Today's Date:___________

Please fill out the grid below and those questions following. Please do not skip sections. It is important that I get a complete history for your records.

1 Not a Problem	2 A Mild Problem	3 A Moderate Problem	4 A Serious Problem
YOUR PHYSICAL FUNCTIONS		YOUR WORK EXPERIENCE	
Sleep too much	1 2 3 4	General Performance	1 2 3 4
Can't get to sleep or stay asleep	1 2 3 4	General Satisfaction	1 2 3 4
Appetite change	1 2 3 4	Lateness	1 2 3 4
Weight Gain	1 2 3 4	Absenteeism	1 2 3 4
Weight Loss	1 2 3 4	Relating to Co-workers	1 2 3 4
Sexual Functioning	1 2 3 4	Negative feelings about work	1 2 3 4
Fatigue/Lack of Energy	1 2 3 4	Relating to your Supervisor	1 2 3 4
YOUR INNER THOUGHTS		PROBLEM AREAS	
Trouble Concentrating	1 2 3 4	Problems with Raising children	1 2 3 4
Memory Problems	1 2 3 4	Dealing with someone else's alcohol/drug use	1 2 3 4
Thoughts of Hurting Self	1 2 3 4	Death of a loved one	1 2 3 4
Thoughts of Hurting Others	1 2 3 4	History of Sexual Abuse	1 2 3 4
Excessive Worries	1 2 3 4	History of physical abuse	1 2 3 4
Worried about gaining too much weight	1 2 3 4	Family Violence	1 2 3 4
Thinking about something over and over	1 2 3 4	Relating to Your Spouse or Partner	1 2 3 4
		Having health problems	1 2 3 4
YOUR FEELINGS AND MOODS			
Depressed/Sad a lot	1 2 3 4	YOUR BEHAVIOR	
Frequent Crying	1 2 3 4	Letting others take advantage of you	1 2 3 4
Feeling Angry Often	1 2 3 4	Violent toward others	1 2 3 4
Irritability	1 2 3 4	Keep to yourself most of the time	1 2 3 4
Doesn't Like Self	1 2 3 4	Attempted to hurt self	1 2 3 4
Sudden Change in Moods	1 2 3 4	Difficulty with daily routine	1 2 3 4
Anxiety/Nervousness	1 2 3 4	Do not have friends who are supportive	1 2 3 4
Becomes easily Frustrated	1 2 3 4	Using alcohol/drugs to cope with problems	1 2 3 4
Feels Lonely	1 2 3 4	Suicidal Actions	1 2 3 4
No longer enjoy things you used to enjoy	1 2 3 4	Repeating certain acts over and over	1 2 3 4
Hopelessness	1 2 3 4		

What is the primary problem that has bought you to counseling? ______________________

Please list the goals you hope to achieve in counseling (Be specific). ______________________

Have you been in therapy before?__________When?______________Was it helpful?__________

Names of prior Mental Health/Chemical Dependency Providers:______________________

Current Medication Information

Current Medication	Dosage	Started When?	What Condition?	Prescribed by?

Primary Physicians Name?______________________Phone:__________

Last Physical Exam?__________________

Other Current Healthcare Providers:______________________

Please list additional medical conditions, past and present: ______________________

Have you ever had a head injury?__________Year of head injury?__________

Religious Affiliation or Spiritual Focus:______________________

Is your religion or Spirituality important to you: □ Not at all □ Somewhat □ Very

How many years of education do you have?____________Highest Degree Earned____________

How many times have you been married?____Divorced?___Are you currently separated?___

What are your hobbies and interests?______________________

Your Social Support System includes:______________________

Please provide any other information you think is important: ______________________

SUBSTANCE USE HISTORY

SUBSTANCE	Amount used during **last** month	None	Amount used at **highest** frequency & year
Coffee-tea-energy drinks			
Cigarettes			
Alcohol			
Marijuana			
Cocaine			
Amphetamines (uppers)			
Barbiturates (downers)			
Tranquilizers			
Hallucinogens			
Opiates			
Other:________________			

Thank you for completing this lengthy and very personal questionnaire. This will provide a more complete intake and foundation for our work together.