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General Questionnaire

Name: _____
Date of Birth: _____ Age: ____
Address: _____
City: _____ State: _____ Zip: _____
Phone Contact(s):_____
Email: _____

Emergency contact: _____

What reason or concern brings you to my office?

_____
_____
_____

How would you rate the severity of the problem/concern?
□ mild □ moderate □ severe □ very severe

When did this begin?

_____
_____
_____

What, if anything, has been helpful?

_____
_____

What, if anything, has made it worse?

_____
_____

Please list previous mental health treatment (dates/therapist/helpful experiences?)

_____
_____
_____

Have you or do you current see a psychiatrist (MD level mental health provider)?

_____
_____

Do you take any medications (please list)?

What past medical problems have you had?

Have you ever been hospitalized overnight? If yes, for what reasons and when?

Have you had any serious accidents or injuries? If yes, please list.

Any mental health or psychiatric problems in your family-of-origin?

What do you hope to achieve in working with me?

How do you handle/manage life stress?

Anything else that you'd like me to know about you or your life history?