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CLINICAL PSYCHOLOGY
psychotherapy • assessment • consultation

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INITIAL CONSULTATION QUESTIONNAIRE

Name: _____Date of Birth: _____

For what problems are you seeking consultation today?

What would you like to get out of this visit?

Whose idea was it for you to be seeking help?

If someone other than you, are you okay with this idea?

Psychiatric History:

Have you ever seen a therapist or psychiatrist in the past?
If yes,

Whom?

When?

Why?

Was it helpful?

Are you or have you ever been on psychiatric medications?
If yes,

What?

When?

Why?

Was it helpful?

Name(s) of the Prescribing psychiatrist?

Have you ever been psychiatrically hospitalized?
If yes,

When?

Where?

Why?

Was it helpful?

Family History:

Who do you live with? Ages and relationships to you:

Indicate if any family members or relatives have any of the followings: Please indicate whom:

___ADD/ADHD:

___Alcohol/Drug abuse:

___Depression:

___Anxiety/OCD/Phobias, etc:

___Eating disorders:

___Suicide:

___Serious illness:

___Physical handicaps:

___Abuse victim:

___Abusive to others:

___Aggressive behaviors:
Additional comments:

Medical History:

Do you have or have you ever had any significant medical problems or been hospitalized, including past surgeries?
If yes, please list:

Are you currently in treatment for any medical condition?

Are you currently taking any medications, including herbal and over the counter medicines?
If yes, please list:

Do you have allergies to any type of food or medications?

Name of primary care physician and any specialty physician, you are currently under their care:

Are you currently working with any other health professional, such as nutritionist, acupuncturist, etc?
If yes, please indicate name(s) and phone number(s):

Alcohol and Drug Use:

Do you use alcohol?
If yes, how much and how often:

Do you use recreational drugs?
If yes, what kind, how much and how often:

Do you feel you have or have had a problem with use of alcohol or drugs?
If yes, explain:

Indicate any previous treatment for alcohol or drug use:

Have you had any history of DUI?
If yes, when?

Please check items below that apply to your current condition: Please note specifics as indicated:

___Headaches:

___Dizziness:

___Stomach/bowel problems:

___Pain:

___Tremors/Tics:

___Sleep Problems:
- **___Falling sleep:**
- **___Staying sleep:**
- **___Sleeping too much: average number of hours:**
- **___Sleeping too little: average number of hours:**

___Weight loss:

___Weight gain:

___Loss of appetite:

___Eat little to lose weight:

___Vomit food intentionally:

___Binge and/or overeat:

___Low energy:

___Feelings of worthlessness:

___Feeling apart from others:

___Memory Problems:

___Concentration Problems:

___Feeling depressed:

___Self injury

___Thoughts of suicide:

___Planning suicide:

___Crying a lot:

___Unable to have a good time:

___Anxiety:

___Fears:

___Always worried:

___Nightmares:

___Panic attacks:

___Recurring unwanted thoughts and behaviors:

___Restlessness:

___Decreased need for sleep:

___Mood swings:

___Excess energy&/or feeling wired:

___Confusion:

___Elated/euphoric mood:

___Excessive spending:

___Racing/overflow of thoughts

___Irritable:

___Impulsive behaviors:

___Grandiose thoughts/plans:

___Anger/explosiveness:

___Hear voices other do not hear:

___See things other do not see:

___Strange experiences:

___Feel people plot against me:

___Constant suspiciousness/distrust

___Usual thoughts:

___Someone physically harming you:

___Thoughts of physically harming another person:

___Violent/aggressive behaviors:

___Physical abuse:

___Sexual abuse:

___Relationship problems:

___Financial problems:

___Conflicts in family:

Additional Comments:

_____ _____

Patient(Parent/Guardian) ***signature*** Witness

_____ _____

Patient (Parent/Guardian) ***print name*** Date