

**CONFIDENTIAL QUESTIONNAIRE**

FILL OUT THE INFORMATION THAT APPLIES TO YOU. LEAVE BLANK ANY QUESTIONS THAT YOU DO NOT FEEL COMFORTABLE ANSWERING OR THAT DO NOT APPLY.

TODAY'S DATE \_\_\_\_\_

NAME \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ ALTERNATE PHONE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_

NUMBER OF BROTHERS \_\_\_\_\_ NUMBER OF SISTERS \_\_\_\_\_ YOU ARE THE \_\_\_\_\_ CHILD.

HIGHEST LEVEL OF EDUCATION \_\_\_\_\_

MENTAL HEALTH/PSYCHOLOGY COURSEWORK \_\_\_\_\_

RELIGIOUS PREFERENCE: NOW: \_\_\_\_\_ IN CHILDHOOD: \_\_\_\_\_

EMPLOYER \_\_\_\_\_ POSITION \_\_\_\_\_

SINGLE  LIVING TOGETHER  MARRIED  PARTNERED  HOW LONG \_\_\_\_\_

ENGAGED  SEPARATED  DIVORCED  WIDOWED

NUMBER OF PREVIOUS MARRIAGES \_\_\_\_\_ FIRST NAMES OF PREVIOUS MATES, NUMBER OF YEARS TOGETHER AND NUMBER OF CHILDREN BORN TO THAT RELATIONSHIP \_\_\_\_\_

MOTHER'S OCCUPATION \_\_\_\_\_ HER AGE \_\_\_\_\_ AGE AT DEATH \_\_\_\_\_

CAUSE OF DEATH \_\_\_\_\_

FATHER'S OCCUPATION \_\_\_\_\_ HIS AGE \_\_\_\_\_ AGE AT DEATH \_\_\_\_\_

CAUSE OF DEATH \_\_\_\_\_

HOW WOULD YOU RATE YOUR PARENTS MARRIAGE? VERY HAPPY  HAPPY  AVG  UNHAPPY

IF DIVORCED, WHAT WAS YOUR AGE WHEN THIS OCCURRED? \_\_\_\_\_

YOU WERE REFERRED BY: SELF  OTHER \_\_\_\_\_

YOUR CHILDREN: LIST NAME, AGE, SEX, COMMENTS (CUSTODY, SUPPORT, ETC)

\_\_\_\_\_  
\_\_\_\_\_

**YOUR PRESENT HEALTH**

EXCELLENT  AVERAGE  POOR  DATE OF LAST PHYSICAL: \_\_\_\_\_

FINDINGS \_\_\_\_\_

ARE YOU PRESENTLY ON ANY MEDICATIONS? YES  NO  IF YES, WHAT KIND, FOR WHAT?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NAME OF PRIMARY CARE PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

LIST PREVIOUS PSYCHOTHERAPY, COUNSELING, OR PERSONAL/MARITAL TREATMENT; ALSO LIST IF YOU HAVE EVER BEEN DIAGNOSED WITH A MENTAL HEALTH OR SUBSTANCE ABUSE DISORDER:

*DATE*                      *TYPE OF PROBLEM*                      *NAME OF PRACTITIONER OR AGENCY*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HAVE YOU EVER BEEN HOSPITALIZED FOR PSYCHIATRIC CARE? YES  NO   
IF YES, WHEN, WHERE, FOR WHAT?

\_\_\_\_\_  
\_\_\_\_\_

ANY OTHER INFORMATION THAT COULD HELP THE THERAPIST NOT OTHERWISE INCLUDED HERE?

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