

# Questionnaire

---

**What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can.**

**What are your goals for counseling?**

**Have you seen a mental health professional before?**

- Yes
- No

**Specify all medications and supplements you are presently taking and for what reason.**

**If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.**

**Who is your primary care physician? Please include type of MD, name and phone number.**

**Do you drink alcohol?**

- Yes
- No

**Do you use recreational drugs?**

- Yes
- No

**Do you have suicidal thoughts?**

- Yes
- No

**Have you ever attempted suicide?**

- Yes
- No

**Do you have thoughts or urges to harm others?**

- Yes
- No

**Have you ever been hospitalized for a psychiatric issue?**

- Yes
- No

**Is there a history of mental illness in your family?**

Yes

No

**If you are in a relationship, please describe the nature of the relationship and months or years together.**

**Describe your current living situation. Do you live alone, with others. With family, etc...**

**What is your level of education? Highest grade/degree and type of degree.**

**What is your current occupation? What do you do? How long have you been doing it?**

**Please check any of the following you have experienced in the past six months**

- Increased appetite
- Decreased appetite
- Trouble concentrating
- Difficulty sleeping
- Excessive sleep
- Low motivation
- Isolation from others
- Fatigue/low energy
- Low self-esteem
- Depressed mood
- Tearful or crying spells
- Anxiety
- Fear
- Hopelessness
- Panic
- Other

**Please check any of the following that apply**

- Headache
- High blood pressure
- Gastritis or esophagitis
- Hormone-related problems
- Head injury
- Angina or chest pain
- Irritable bowel
- Chronic pain
- Loss of consciousness
- Heart attack
- Bone or joint problems
- Seizures
- Kidney-related issues
- Chronic fatigue
- Dizziness
- Faintness
- Heart valve problems
- Urinary tract problems
- Fibromyalgia
- Numbness & tingling
- Shortness of breath
- Diabetes
- Hepatitis
- Asthma
- Arthritis
- Thyroid issues
- HIV/AIDS
- Cancer
- Other

**What else would you like me to know?**