

CLINICAL QUESTIONNAIRE

(Patients 14 years old and up)

This questionnaire is designed to supply your therapist with comprehensive information about your past history and present situation. By completing these questions as fully and accurately as you can, you will facilitate your clinical assessment and therapy program. Thank you.

1. General Information:

Date: _____

Name: _____ Spouse name: _____

Address: _____ Sex: Male Female

_____ Age: _____ Date of Birth: _____

Phone number _____ Home Cell Work

Phone number _____ Home Cell Work

Marital Status (please check one of the following):

Single Engaged Married Divorced Remarried Living together Widowed

Do you have any children? Yes _____ No _____

If so, please list names and ages below:

<u>NAME:</u>	<u>AGE:</u>	/	<u>NAME:</u>	<u>AGE:</u>
_____	_____	/	_____	_____
_____	_____	/	_____	_____
_____	_____	/	_____	_____
_____	_____	/	_____	_____

Primary Care Physician (PCP): _____

Address: _____

Health Insurance: _____

2. Current Clinical Data:

(a.) Describe the main problem(s) that led you to seek therapy at this time, including the duration of this problem (or set of problems):

(b.) Briefly describe the history of this problem, or set of problems, including a list of stress factors which seem to be triggering and/or intensifying the problem now:

(c.) Circle the degree to which you have been experiencing each of the following Moods, Emotions and Feelings as a result of the problem(s) that led you to seek therapy:

	Not at all	To only a Mild Degree	To a Moderate Degree	To a Very Strong Degree
1. Angry	0	1	2	3
2. Panicky	0	1	2	3
3. Depressed	0	1	2	3
4. Ashamed	0	1	2	3
5. Bored	0	1	2	3
6. Irritable	0	1	2	3
7. Fearful	0	1	2	3
8. Suspicious	0	1	2	3
9. Empty	0	1	2	3
10. Lonely	0	1	2	3
11. Resentful	0	1	2	3
12. Dependent	0	1	2	3
13. Confused	0	1	2	3
14. Guilty	0	1	2	3
15. Nervous	0	1	2	3
16. Listless	0	1	2	3
17. Hopeless	0	1	2	3
18. Tense	0	1	2	3
19. Sad	0	1	2	3
20. Mistrustful	0	1	2	3
21. Terrified	0	1	2	3
22. Embarrassed	0	1	2	3
23. Elated	0	1	2	3
24. Abandoned	0	1	2	3
25. Agitated	0	1	2	3
26. Worried	0	1	2	3
27. Helpless	0	1	2	3
28. Grief	0	1	2	3

Other emotional reactions:

Circle how often you have been bothered by each of the following Difficulties with Thinking since the problem(s) that led you to seek therapy began:

	Never	Occasionally	Often
1. Concentration difficulties	0	1	2
2. Difficulty remembering things	0	1	2
3. Your mind going "blank"	0	1	2
4. Difficulty making decisions	0	1	2
5. Difficulty making sound judgments	0	1	2
6. Distractible	0	1	2
7. Thoughts are "racing"	0	1	2
8. Unwanted and/or intrusive thought(s), image(s), or urge(s)	0	1	2
9. Repetitive thought(s), image(s), or urge(s)	0	1	2
10. Suicidal thoughts	0	1	2
11. Thoughts of killing someone	0	1	2
12. Preoccupation with death	0	1	2

Other problems not listed above:

Circle how much you have been distressed or bothered by each of the following Physical Reactions since the onset of the problem(s) that led you to seek therapy:

	Not at All or Only a Minimal Degree	To a Moderate Degree	To a Very Strong Degree
1. Shortness of breath or smothering sensations	0	1	2
2. Nausea, diarrhea, or other abdominal stresses	0	1	2
3. Trouble swallowing or "lump in throat"	0	1	2
4. Muscle tension, aches, or soreness	0	1	2
5. Flushes (not flashes) or chills	0	1	2
6. Dizziness or light-headed	0	1	2
7. Trouble falling or staying asleep	0	1	2
8. Sweating or cold clammy hands	0	1	2
9. Fatigue or loss of energy	0	1	2
10. Decrease in appetite	0	1	2
11. Weight loss	0	1	2
12. Decreased need for sleep	0	1	2
13. Numbness or tingling sensations	0	1	2
14. Weepiness/crying	0	1	2
15. Palpitations or accelerated heart rate	0	1	2
16. Headaches	0	1	2
17. Increase in appetite	0	1	2
18. Weight gain	0	1	2
19. Increased need for sleep	0	1	2
20. Chest pains or discomfort	0	1	2
21. Physical problems (for example, impaired physical functioning, physical pain, etc.)	0	1	2
22. Awakening earlier in the morning than you normally do.	0	1	2

Other physical reactions: _____

Circle the degree to which you have been experiencing each of the following additional reactions since the onset of the problem(s) that led you to seek therapy:

	Not at All	To Only a Mild Degree	To a Moderate Degree	To a Very Strong Degree
1. Feeling as if things were not real	0	1	2	3
2. Feeling little or no interest in things	0	1	2	3
3. Feeling little or no pleasure from activities	0	1	2	3
4. Having nightmares or distressing dreams	0	1	2	3
5. Problems with sexual functioning	0	1	2	3
6. Feeling detached from (as if an observer of) your own mental processes or body	0	1	2	3
7. Feelings of inadequacy or worthlessness	0	1	2	3
8. Feelings like you want to beat or harm someone	0	1	2	3
9. Wanting to avoid certain things, places, people, or activities	0	1	2	3
10. Social withdrawal	0	1	2	3
11. Temper outbursts	0	1	2	3
12. Excessively checking things, counting things, washing, or other repetitive action(s) that you feel you must perform	0	1	2	3
13. Having strange and peculiar experiences (for example: hearing voices, seeing shadows or images, etc.)	0	1	2	3
14. Increased alcohol use	0	1	2	3
15. Use of "street" (non-prescription) drugs	0	1	2	3

Any other effects or reactions; stemming from your problem(s), not described above: _____

(d.) Family Functioning: Briefly describe how *the problems you are having*, have been affecting your relationship with family members (i.e. spouse, partner, children and other significant relatives):

(e.) Social Functioning: Briefly describe how *the problems you are having*, have been affecting your social functioning with non-family members (i.e. relationship with friends):

(f.) Work/ School Functioning: Briefly describe any ways that you feel your functioning at work and, if relevant, at school, has been affected by *your current problem(s)* (i.e. performance levels, relationship with co-workers)

(g.) Please place a checkmark in the appropriate box for each of the following

Have you ever:	Present	Past	Future
1. Purposely injured yourself without suicidal intent (e.g. cut, hit, burned, etc.)			
2. Seriously considered attempting suicide			
3. Made a suicide attempt			
4. Considered seriously injuring another person			
5. Intentionally caused serious injury to another person			
6. Had unwanted sexual contact(s) or experience(s)			
7. Experienced harassing, controlling, and/or abusive behavior from another person (e.g., friend, family member, partner, or authority figure)			
8. Been hit, punched, slapped, kicked, or otherwise physically harmed by a person (e.g. friend, family, partner, or authority figure) with cruel or malicious intent			
9. Been involved in child abuse a.) as a victim/survivor b.) as a perpetrator			
10. Been involved in sexual abuse a.) as a victim/survivor b.) as a perpetrator			
11. Had an eating disorder			
12. Felt that something was wrong with your mind			
13. Physically threatened another person			
14. Assaulted or attempted to kill another person			
15. Felt your thoughts were so loud people could hear them			
16. Had periods of time you can't account for			
17. Had periods of severe depression			
18. Believed others were conspiring against you			
19. Had periods in which you felt extremely optimistic, full of energy, could get by on little or no sleep, and/or thought and talked very fast			
20. Felt compelled to help other people			
21. Felt compelled to isolate yourself			

(h.) Please describe your experiences with each of the following:

Substance	Amount of Use	Frequency of Use	Age at First Use	Age at Last Use	Used in Last 48 Hours	Used in Last 6 Months
Alcohol					Y N	Y N
Nicotine					Y N	Y N
Marijuana					Y N	Y N
Other (fill in):					Y N	Y N
Other (fill in):					Y N	Y N
Other (fill in):					Y N	Y N
Other (fill in):					Y N	Y N

If you have used alcohol:

1. Have you ever tried to cut down on your drinking? Yes No
2. Have you ever been annoyed at other's complaints about your drinking? Yes No
3. Have you ever felt guilty about your drinking? Yes No
4. Have you ever taken a morning "eye opener" (drink)? Yes No

Are there particular situations in which drug or alcohol use tends to occur? Yes No

If Yes, please describe:

Is your current use of alcohol and/or drugs causing or contributing to problems in any aspect of your functioning (relationship with others, functioning at work or school, etc,)?

Yes No

If yes, describe the nature of the problem(s) stemming from your current use of alcohol and/or drugs:

3. Historical Clinical Data

a.) Have you had any previous issues for which you feel a mental health professional should have been seen, or for which you actually did seek professional help? Yes No

If yes, state the issue(s):

Did you receive professional help for these issues: Yes No

If you were seen as an *outpatient*, indicate when and where you were seen and the name(s) of the professional(s) with whom you were in treatment:

(c.) Were you adopted as a child? Yes No

(d.) Were you diagnosed as a hyperactive child? Yes No

(e.) Were your parents separated or divorced as a child? Yes No

(f.) Were either of your parents seriously physically ill and/or absent for long periods of time during your growing up years? Yes No

(g.) Briefly describe any experiences that you had while growing up that you believe may have a bearing on your present problem(s):

(h.) Spouse/Partner Name: _____ Age _____

Occupation _____ Years married _____

How would you describe your spouse or partner, and how do you get along with him or her?

If divorced/divorcing, reason for divorce?

(i.) Repeat the above for 2nd spouse:

6. Social/Educational/Employment/Legal Data

(a.) Briefly describe any aspects of your social history, other than in your family of origin, which you believe may have a bearing on your present problem(s):

(b.) Indicate the highest level of formal education that you have obtained:

(c.) Briefly describe any experiences relating to school that you think may have a bearing on your present problem(s):

(d.) Indicate your current occupation: _____

(e.) How many times have you changed jobs in the last 5 years? _____

(f.) Are you a combat veteran? Yes No

If yes, which War(s):

(g.) Have you had any problems of a legal nature (including arrests)? Yes No

If yes, briefly describe what this involved:

7. Medical Data

(a.) If you have had any past or current medical illnesses, surgeries, or traumas, give a brief description of these, including when they occurred:

Dates	Incident	Treating Physician

(b.) List any current medications, including dosage, that you take:

Medication	Dosage	Reason Taken	# of times of day taken	# of days a week taken	Prescribing Physician
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	

(c.) Indicate any allergies that you have:

(d.) The date of your last physical: _____