ORANGE COUNTY PSYCHOTHERAPY ASSOCIATES, INC.
Psychotherapy Client Questionnaire

Name: _____ Date: _____

REFERRED BY:

Name: _____ Phone#: _____

May I inform this person that you have consulted with me? _____

1. GENERAL

A. Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone:_____ E-Mail: _____

*Please indicate preferred method of contact_____

Age: _____ Date of Birth: _____ Place of Birth: _____

Social Security #_____Driver's License #_____

Employment and Address_____

_____

Medical Insurance _____

Insured Name (if different) _____SS#_____D.O.B_____

Policy #_____Group #_____

Insurance consent: I, the undersigned certify that I (or my dependent) have insurance coverage with the insurance company indicated above. I assign directly to Orange County Psychotherapy Associates, Inc., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize my therapist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Relationship Date

B. What is your present living situation? ___

_____

C. Names and ages of children

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

D. Work and Education

Education: _____

Occupation: _____

Currently working: _____

What is your present job situation? _____

_____

2. PROBLEM AREA

A. State in your own words the nature and history of your chief complaint:

_____

_____

_____

B. Present interests, hobbies, activities:_____

_____

_____

_____

D. What are your expectations of our work together in psychotherapy?

_____

_____

_____

_____

_____

E. What issues do you anticipate working on in therapy?

1._____

2._____

3._____

4._____

5._____

3. FAMILY HISTORY

A. Father's name: _____

Age: _____ Health: _____

If deceased, age and cause of death: _____

_____

Your age at time of father's death: _____

Give a brief description of your father's personality:

_____

_____

_____

_____

_____

_____

_____

B. Mother's name: _____

Age: _____ Health: _____

If deceased, age and cause of death: _____

_____

Your age at time of mother's death: _____

Give a brief description of your mother's personality:

_____

_____

_____

_____

_____

_____

_____

C. Brothers/Sisters (Names, sex, age, and something about each):

[Are there other significant others from your growing up years?]

_____

_____

_____

_____

_____

_____

_____

D. Who are the most important people in your life? Describe.

_____

_____

_____

4. Previous Medical, Psychiatric, and Psychotherapy Contacts

A. Have you ever been in psychotherapy before?_____

If yes, when? _____

May I contact your previous therapist(s)? _____

Therapist:_____

Address: _____

Phone: _____

Therapist: _____

Address:_____

Phone: _____

B. Have you ever been hospitalized for an emotional problem?

If yes, when, where, and how long?_____

_____

D. Have you ever made a suicide attempt? If yes, describe it, when, and the circumstances leading up to the attempt.

_____

_____

_____

_____

E. Have any close relatives been treated for psychiatric problems?

If yes, please specify:_____

_____

_____

F. Has any relative of yours committed suicide?

If yes, please specify:_____

_____

_____

5. Give a brief history of any litigation you have been involved in regarding child custody, divorce, liability, or medical malpractice.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

6. MEDICAL HISTORY

A. Have you had any of these childhood illnesses?

	NO	**YES**	**DON'T KNOW**
Measles	___	___	_____
Mumps	___	___	_____
Whooping cough	___	___	_____
Chicken pox	___	___	_____
Rheumatic fever	___	___	_____
Rubella (German measles)	___	___	_____

Please list all medical hospitalizations and operations. Give diagnoses and dates:

_____

_____

B. Have you ever suffered from any of the following illnesses?

	NO	YES	DATE OF ONSET
Cancer	___	___	_____
TB	___	___	_____
Diabetes	___	___	_____
Thyroid trouble	___	___	_____
Kidney trouble	___	___	_____
High blood pressure	___	___	_____
Eye trouble	___	___	_____
Heart trouble	___	___	_____
Neurological disease	___	___	_____
Ulcers	___	___	_____
Head injury	___	___	_____
D.T.'s	___	___	_____
Allergies	___	___	_____

List all allergies: _____

_____

Any other serious illnesses? _____

C. Family Medical History

Have any of your blood relatives suffered from any of the illnesses listed above or otherwise? If yes, please specify ailment and relative:

_____

_____

_____

D. Drug/Medication History

Because many drugs (legal and illegal) have psychological effects, it is important for me to know what drugs you are *currently* taking and/or *have taken in the past*. This

information will remain strictly confidential, but it is very important for me to know before you begin therapy so that an accurate assessment of your problem and situation can be made. Please list *all* legally prescribed and illegal drugs ever used (past or present) and describe how often you use them and what effects you seek:

_____

_____

_____

_____

_____

_____

Have any of these drugs been prescribed by a physician?

Yes _____ No _____ If so, which drugs and for what reason?

_____

_____

_____

_____

E. Nutrition

Is your diet unusual in any way? Yes _____ No _____

If so, how? _____

_____

_____

_____

F. Symptoms

Check any of the following symptoms that apply to you at this time. Also indicate when any of these symptoms have applied to you in the past.

Hair falling out	_____	Fainting spells	_____
Weight gain	_____	Difficulty sleeping	_____
Fatigue	_____	Drinking too much fluid	_____
Constipation	_____	Blurred vision	_____
Dry skin	_____	Deafness	_____
Weakness	_____	Ringing in ears	_____
Weight loss	_____	Chest pain	_____
Tremor	_____	Shortness of breath	_____
Big appetite	_____	Tingling of hands or feet	_____
Fast heart beat	_____	Ankle swelling	_____
Diarrhea	_____	Indigestion	_____
Poor appetite	_____	Nausea or vomiting	_____
Headaches	_____	Urinary difficulties	_____
Dizziness	_____	Problems with sexual organs	_____

G. Menstrual History, Issues, or Problems:_____

_____

_____

_____

H. Smoking and Drinking

Do you smoke (anything)? _____ What? _____How much? _____

Frequency? _____Do you drink alcohol? _____ If yes, how much? _____What happens to you when you smoke or drink, that is, what does it do for you?_____

_____

Describe any physical symptoms at all that you have when you smoke or drink.

I. What kind, and how much physical exercise do you get?

_____

_____

_____

J. Describe the spiritual/religious aspects of your life:

_____

_____

_____

_____

_____

K. Have you ever been on worker's comp or disability? For what, how long, results?

_____

_____

_____

_____

_____

L. In case of emergency, please notify one of the following three people: May I have your permission to inform one or all of these people if you are ever in danger?

Yes _____ No _____

1.

_____

Name	Daytime	Evening
Address	Phone	Phone

2.

_____

Name	Daytime	Evening
Address	Phone	Phone

3.

_____

Name	Daytime	Evening
Address	Phone	Phone

This questionnaire supplements previous informed consents.

_____

Your Name (please print)

_____ _____

Your Signature Date

_____ _____

Parent or Legal Guardian Signature Date

For Therapist Use Only!

Diagnostic Impressions: _____ Date _____

_____

_____

Treatment Plan:_____Date _____

_____

_____

_____

Referrals:

_____ Date _____

_____ Date _____