EMPOWERED BEHAVIORAL HEALTH

NEW CLIENT INITIAL QUESTIONNAIRE

Please complete this before your first session. Completing this questionnaire will help us better understand your needs and develop a comprehensive plan together. Thank you for taking the time to fill out this form.

Name____

Age: _______________ DOB: ___________________

Referring provider ____ Referrer's phone _______________________

Primary Care Physician____________________________________ PCP's Phone _______________________

Current Therapist __________________________________ Therapist's Phone_______________________

Current Psychiatrist/Psychopharmacologist __________________________ Prescriber's Phone_________________

What are the reason(s) you are seeking help?

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____

What are your treatment goals?

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____

Have you ever been in counseling or therapy before? If so, explain (when, why, and what type of treatment).

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____

Current Living Situation

Please list all immediate family members as well as other people currently living in your home. Put a star (*) next to the people that currently live with you.

Name	Age	Relationship	Occupation/grade

Social History

Where were you born? ____

Where did you grow up? ____

How many siblings do you have? None _________Brothers _________Sisters__________

Did you suffer from any major illnesses/injuries while you were growing up? □ Yes □ No
If so, please describe.

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____
____

Please describe your childhood.

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____
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____

Highest level of education: ____________ Degree: _________________ Field of study: _______________________

What is your current employment status?
□ Employed (Where and what do you do? How long have you worked at your current job?)

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□ Retired from and when ____
□ Unemployed (reason) ____

What types of jobs have you had in the past?

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____
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Are you currently involved in a romantic relationship? □ Yes □ No

Relationship Status: □ Single □ Dating □ Life Partner □ Married □ Divorced □ Widowed

Spouse/partner's name: _________________________ How long have you been together? _______________

How would you describe your relationship?

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____

Do you feel like you have a strong support system (family, friends)? □ Yes □ No

Please describe your interests and hobbies.

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____

Please describe your spiritual orientation and how important religion/spiritual beliefs are in your life?
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____
____

Have you had any legal issues (e.g., arrests, charges, time in jail)? □ Yes □ No. If so, please describe.
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____

Medical history

Do you have any physical symptoms that concern you? □ Yes □ No If Yes, please list:
Do you have any concerns regarding your health: □ Yes□ No If Yes, please list:
Are you currently being treated for any medical conditions? □ Yes □ No If Yes, please list:
Are there any specialists involved in your care? □ Yes □ No If Yes, please list name of provider, specialty and reason for seeing them:

Please list all current medications you are taking, including any vitamins or herbal supplements:

Medication name	Reason for taking	Dose	Is it effective?	Any side effects?

Please list all allergies or any adverse drug reactions:
____
____
____

Psychiatric history

Have you been ever diagnosed with a mental health condition (e.g. Depression, bipolar, schizophrenia, ADHD)? If so, please list all diagnoses.

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____
____

Have you ever experienced verbal, physical, emotional, or sexual abuse? Or been the victim of a violent crime? If so, please describe.

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____
____

Have you ever been hospitalized for a psychiatric reason? □ Yes □ No
If YES, please list and describe.

Date/s	Location and reason	Type of treatment during stay

Have you ever taken any medications for emotional, behavioral, or psychological reasons? □ Yes □ No
If yes, please list all medications, including ones you no longer take.

Dates	Medication name	Reason for taking	Dose	Was it effective?	Any side effects?

Substance Use history

Please describe your experience with the following substances.

Substance	Age when started	Frequency of use (per day/wk/mo)	Amount of use	Have you ever received treatment for misuse? If so, when?
Caffeine				
Tobacco				
Alcohol				
Cannabis/Marijuana				
Amphetamines/ Stimulants				
Cocaine				
Hallucinogens				
Opiates/heroin				
Inhalants				
Sedative/hypnotics				
Prescription medication (for recreational reasons)				

Family Mental Health History

Is there any known history of the following conditions in your family?

Condition	Mother	Father	Sibling	Children	Other member
Alcohol or drug abuse					
Anxiety (e.g., Panic, Worry, Phobia, OCD)					
Schizophrenia					
Depression					
Bipolar Disorder					
Eating Disorder (Anorexia or Bulimia)					
Prior Inpatient Psychiatric Hospitalizations					
Prior Completed or Attempted Suicide					

Safety

Do currently have thoughts of hurting yourself or ending your life? □ Yes □ No
If so, please describe.

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Have you ever attempted suicide? □ Yes □ No
If so, please explain.

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Do you engage in self-harm behaviors like cutting, burning picking, or other forms of self-injury? □ Yes □ No
If so, please describe.

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CHECK ITEMS THAT APPLY TO WHAT YOU HAVE BEEN EXPERIENCING RECENTLY:

__ headaches
__ dizziness
__ stomach problems
__ bowel problems
__ feel tense
__ irritable
__ unusual thoughts
__ strange experiences
__ weight change
__ always tired
__ can't go to sleep
__ racing thoughts
__ restrict food intake
__ identity concerns
__ work conflict
__ nightmares
__ sexual problems
__ financial problems
__ depressed/sad
__ panicky feelings
__ feel hopeless
__ always worried
__ unable to relax
__ feel worthless
__ hard to make decisions
__ thoughts of suicide
__ enjoy high-risk situations
__ binge/purge
__ test anxiety
__ career/future confusion
__ can't stay asleep
__ ready to explode
__ unable to work/study
__ can't get interested
__ can't have a good time
__ trouble concentrating
__ can't make/keep friends
__ fear loss of self-control
__ feel apart from family
__ fear things I shouldn't
__ conflict within family
__ don't need a lot of sleep
__ thoughts of self-harm
__ acts of self-harm
__ motivation challenges

OTHER current feelings or symptoms not mentioned above: ____
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____