

Initial Questionnaire & Assessment

Name

Age

Date

Marital status

Occupation

In your own words, please describe why you are seeking help:

Current Symptoms/Concerns:

Anxiety, nervousness, worry a lot	<input type="checkbox"/>
Compulsions (a strong urge to repeat certain actions)	<input type="checkbox"/>
Obsessive thoughts (repetitive unpleasant thoughts that are hard to get rid of)	<input type="checkbox"/>
Overly shy & hypersensitive to criticism	<input type="checkbox"/>
Panic/anxiety attacks	<input type="checkbox"/>
Depressed mood	<input type="checkbox"/>
Difficulties keeping up with your normal responsibilities	<input type="checkbox"/>
Difficulty making decisions	<input type="checkbox"/>
Disappointed or disgusted with yourself	<input type="checkbox"/>
Frequent crying	<input type="checkbox"/>
Feeling little or no enjoyment or pleasure	<input type="checkbox"/>
Recurrent thoughts of death and dying	<input type="checkbox"/>
Thoughts/urges about hurting self and/or others	<input type="checkbox"/>
Moodiness or mood swings	<input type="checkbox"/>
Irritability, outbursts of anger	<input type="checkbox"/>
Racing thoughts	<input type="checkbox"/>
Impulsive and/or excessive spending of money	<input type="checkbox"/>
Poor attention/concentration	<input type="checkbox"/>
Easily distracted by irrelevant things	<input type="checkbox"/>
Lack of organizational skills	<input type="checkbox"/>
Fatigue, low energy	<input type="checkbox"/>
Forgetfulness	<input type="checkbox"/>
Sexual concerns or difficulties	<input type="checkbox"/>
Sleep problems	<input type="checkbox"/>
Hear or see things other people cannot see or hear	<input type="checkbox"/>
Feel mistreated and/or persecuted by others	<input type="checkbox"/>

Appetite/weight changes (up or down)	<input type="checkbox"/>
Binging with or without purging	<input type="checkbox"/>
Weight or diet issues	<input type="checkbox"/>
Other – please describe:	<input type="checkbox"/>

Current, Recent and Ongoing Stressors

Divorce/separation	<input type="checkbox"/>
Family or marital problems	<input type="checkbox"/>
Financial problems, debt	<input type="checkbox"/>
Lack of friendships, family or social support	<input type="checkbox"/>
Legal problems	<input type="checkbox"/>
Concerns about your or your family member's physical health	<input type="checkbox"/>
Ongoing relationship problems	<input type="checkbox"/>
Parenting issues	<input type="checkbox"/>
Multiple recent losses	<input type="checkbox"/>
Unemployment/underemployment	<input type="checkbox"/>
Victim of abuse	<input type="checkbox"/>
Work stressors	<input type="checkbox"/>
Other – please describe:	<input type="checkbox"/>

Alcohol, Other Substances & Addictions

	Currently	In the past
Alcohol or drug related legal problems	<input type="checkbox"/>	<input type="checkbox"/>
Average more than 7 alcohol drinks a week	<input type="checkbox"/>	<input type="checkbox"/>
Feeling guilty, trying to cut down or have been urged to cut down on alcohol and/or drug use	<input type="checkbox"/>	<input type="checkbox"/>
Gambling	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse treatment	<input type="checkbox"/>	<input type="checkbox"/>
Using marijuana or other street drugs	<input type="checkbox"/>	<input type="checkbox"/>

Mental Health Treatment & Concerns in the Past

Outpatient	<input type="checkbox"/>
Inpatient	<input type="checkbox"/>
Cutting self	<input type="checkbox"/>
Suicide attempt(s)	<input type="checkbox"/>

Psychotropic Medications (for your nerves) You Have Taken In the Past.

Family History Of:

Attention Deficit Disorder	<input type="checkbox"/>	Learning Disability	<input type="checkbox"/>
Alcohol or Drug Abuse	<input type="checkbox"/>	Panic Attacks	<input type="checkbox"/>
Anxiety Disorders	<input type="checkbox"/>	Psychiatric Hospitalizations	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	Suicide	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	Unusual Behavior	<input type="checkbox"/>

How do you rate your physical health?

Excellent Good Fair Poor

Height Weight Allergic to:

Last time you saw your medical physician(s):

Current & Past Health Problems:

Anemia	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Hepatitis or Other Liver Problems	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
Blurred or Otherwise Impaired Vision	<input type="checkbox"/>	Irritable Bowel Syndrome	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Seizures/convulsion	<input type="checkbox"/>
Chest Discomfort/pain	<input type="checkbox"/>	Menstrual problems, PMS, Menopause	<input type="checkbox"/>
Chronic and/or Frequent Infections	<input type="checkbox"/>	Joint or Muscle Pain or Swelling	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Migraines	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	Neurologic Disease	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	Problems with Bladder or Bowel Control	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>
Grinding Teeth	<input type="checkbox"/>	Skin Disorders	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	Sleep apnea	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	Unexplained weight loss	<input type="checkbox"/>

Other medical conditions your doctors have diagnosed:

Current Prescribed and Over-the-counter Drugs, Vitamins and Supplements:

Medication	Dose	Frequency taken

Personal History:

Feel free to elaborate as much or as little as you feel comfortable doing prior to our first session

Parents

Siblings

Childhood

Education

Employment

Marriage(s)

Family

Children

Other Pertinent
Information

The above information is true to the best of my knowledge. I consent to treatment at the Mind & Mood Clinic.

Patient/Guardian signature

Date: