

Eileen Drapiza-Dornan, LMFT MFC 51665

Patient Questionnaire/Intake

General:

Name _____ Date _____

Address 1 _____ Home phone _____

Address 2 _____

Work phone _____ Fax _____

E-mail _____ Referred by _____

Age _____ Date of birth _____

Marital status _____ Educational level _____

Occupation _____ Names and ages of children _____

Emergency contact information _____

Explanation of how patient may be contacted by therapist _____

Best times to reach you (give at least two) _____

Preferred method of contact: email / text / phone

Financial Information:

How do you intend to pay for treatment? (cash, check, charge, insurance) _____

If planning to use health insurance:

Name of insurance company _____

Name and Address of Primary Subscriber: _____

Policy number (ID #) _____ Group number _____

Telephone number for Insurance Company (from your insurance card) _____

Areas of Concern

What issues/concerns causes you to seek treatment? Please describe. _____

Do you have any specific goals with regard to your treatment? _____

Do you have any particular concerns/fears with regard to treatment? _____

Psychological History

Have you ever received mental health treatment before? _____

When and for how long? _____

What was the focus of treatment? _____

Name of treating therapist(s), address(es), telephone number(s) _____

Have you ever been subjected to one or more psychological tests? _____

If so, by whom? _____

Name of person(s) administered psychological tests, address(es), telephone number(s)

Have you ever been hospitalized for mental or emotional problems? _____

When and for how long? _____

Why were you hospitalized? _____

Name of treating therapist, address, telephone number _____

Are you currently taking any prescription medications? _____

Prescribed by whom? _____

How long have you been on the medications? _____

Have you ever taken any medications for a mental or emotional condition? _____

When and for how long? _____

Have you ever attempted suicide? _____

When? _____

Describe the circumstances that led to that attempt. _____

Are you currently having any suicidal thoughts? Please describe _____

Note: If applicable, authorization for release of confidential information will be needed so that any former therapist, test administrator, or health care provider may be contacted.

Please describe your childhood _____.

Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe.

Have you ever been a victim of a violent crime? Please describe _____

Medical History

Have you ever been diagnosed with a serious illness? Please describe _____

_____ Do

you have any medical conditions that may affect your mental health treatment? _____

Please describe your overall health today. _____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe. _____

Have you ever been in a 12-step program? Please describe. _____

Do you smoke? _____ How much? _____ For how long? _____

Do you drink alcohol? _____

On average, how much alcohol do you consume in a week? _____

Do you currently use illegal drugs? Please describe your use _____

_____ Have you ever used illegal drugs? Please describe. _____

Family of Origin History

Mother's name, age, living/deceased, patient's age at the time of mother's death, description of relationship with mother. _____

Father's name, age, living/deceased, patient's age at the time of father's death, description of relationship with father. _____

Names and ages of siblings. _____

Other Information

Please describe your spiritual identity/orientation. _____

Please describe your interests/hobbies _____

Are you now or have you ever been involved in a lawsuit? _____

Please describe. _____

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested. _____