CONFIDENTIAL PATIENT QUESTIONNAIRE

Patient Name: _____ Date: _____

Please complete this form to help me as I talk with you regarding your problems. If you are unsure about the answers to any of these questions, please discuss them with me.

Medical/Lifestyle History

Current General Health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Medication(s) currently used:

Medication	Dose	Date Prescribed	Why Prescribed	Prescribing Physician
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Reproductive History (Female Only): Number of Pregnancies: _____ Number of live births: _____

Currently pregnant: ☐ Yes ☐ No ☐ Maybe

Past Hospitalizations (Psychiatric/Chemical Dependency):

Date(s)	Reasons	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

Alcohol Use:

How often do you use alcohol? ☐ None ☐ Monthly ☐ Weekly ☐ Daily

On the days that you drink, how many drinks do you usually have? ☐ Less than 2 ☐ 2-5 ☐ 5 or more

Do you consider it a problem? ☐ No ☐ Yes; Do others consider it a problem? ☐ No ☐ Yes

Do you have problems at work/school because of drinking or drug use? ☐ No ☐ Yes

Have you had problems with alcohol in the past? ☐ No ☐ Yes; Any DUIs? ☐ No ☐ Yes

Nicotine Use:

Do you smoke or use tobacco now? ☐ No ☐ Yes

How much? _____ How long? _____

Have you smoked or used tobacco in the past? ☐ No ☐ Yes

How much? _____ How long? _____

Caffeine:

How many cups of caffeinated coffee/tea do you drink a day? _____

How many caffeinated soft drinks? _____ How much chocolate, cocoa? _____

Drug Use:

Marijuana: ☐ None ☐ Occasionally ☐ Weekly ☐ Daily

Do you use other non-prescription substances? ☐ None ☐ Occasionally ☐ Weekly ☐ Daily

If yes, what substances? _____

Family History

Is there a family history of (check all that apply):

☐ Alcoholism ☐ Substance Abuse ☐ Mental Illness ☐ Domestic Violence ☐ Suicide

If yes, please describe the person's relationship to you and the problem: _____

_____

Which of the following best describes the family in which you grew up?:

Warm and Accepting				Average				Distant, Hostile and Fighting	
1	2	3	4	5	6	7	8	9	10

Growing up, was your family/home disrupted by serious illness/accident/death/separation/divorce? ☐ No ☐ Yes If yes, please describe: _____

_____

Mental Health History:

As a child did you have any problems with:

☐ Learning Disabilities ☐ Hyperactivity ☐ADD/ADHD ☐ Bed Wetting

☐ School Fears ☐ Being Bullied ☐ Depression ☐Anxiety

☐ Sexual or Physical Abuse ☐ Physical Illnesses or Injuries

Have you ever attempted suicide? ☐ No ☐ Yes

Do you currently have suicidal thoughts? ☐ No ☐ Yes

Do you ever feel angry enough at home/work/school to do something you might regret? ☐ No ☐ Yes

Legal History:

☐ None ☐ Litigation ☐ Arrest ☐ Imprisonment ☐ Victimization

Job Satisfaction (If employed):

☐ Very Satisfied ☐ Fairly Satisfied ☐ Not At All Satisfied

Previous Counseling, EAP, or Chemical Dependency Services:

Have you ever seen anyone or are you currently seeing anyone for:

Individual Therapy	☐ No ☐ Yes	Marital/Couples Therapy	☐ No ☐ Yes
Group Psychotherapy	☐ No ☐ Yes	Sex Therapy	☐ No ☐ Yes

If Yes, please list:

Facility/Counselor Name	Dates Seen	Reason Seen	Helpful?
_____	_____	_____	☐ No ☐ Yes
_____	_____	_____	☐ No ☐ Yes
_____	_____	_____	☐ No ☐ Yes
_____	_____	_____	☐ No ☐ Yes
_____	_____	_____	☐ No ☐ Yes

Is there anything else that might be important for me to know about you? _____

_____

_____

_____

_____

_____

_____