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My Situation

Please complete the following questionnaire as completely and honestly as you can. Your answers will help me better understand you and your situation. If you are completing this form anywhere other than my office, please remember that you are responsible for keeping the form confidential.

General Consent

I understand that by completing this form I am requesting services from Dr. Graham, and that he will use the information in this form to determine what services he may be able to offer. If Dr. Graham determines that he is not able to provide services, he will give me appropriate referrals to other professionals.

If Dr. Graham determines that he is able to provide services, I give to him my general consent to use the information in this form. This consent does not allow for the release of any protected health care information to any other person or organization, except when mandated by law. I understand that this consent is governed by the practices described in the document titled *Notice of Privacy Practices for Protected Health Information*. I have received a copy of this document.

I hereby give permission to Dr. Graham to use my protected health information for purposes of treatment and payment.

____ ________________

Signature Date

Presenting Problem

(If you run out of room in any of the following sections, feel free to continue on the back)

Describe the problems you are having and when they began:

____

____

____

Have you been court ordered to discuss this problem? ____ Yes ____ No

What seems to make the problem worse?

____

____

What seems to make the problem better?

____

____

What have you done to try to solve this problem?

____

____

Please check any symptoms you are currently experiencing:

__ Aggression or angry outbursts
__ Alcohol abuse
__ Anxiety
__ Avoidance of people
__ Computer addiction
__ Depression
__ Difficulty concentrating
__ Difficulty thinking
__ Distractibility
__ Dizziness
__ Drug abuse
__ Eating disorders
__ Elevated mood
__ Fatigue
__ Fears (list)
____
____
____
____
__ Hallucinations
__ Headaches
__ Helplessness
__ Hopelessness
__ Impulsivity
__ Indecisiveness
__ Irritability
__ Loneliness
__ Memory problems
__ Mood swings
__ Muscle tension
__ Panic attacks
__ Racing thoughts
__ Restlessness or on edge
__ Sexual addiction
__ Sleeping problems
__ Stressed out
__ Suicidal thoughts
__ Trembling
__ Weight gain/loss
__ Withdrawal
__ Worrying
__ Worthlessness
__ Other Symptoms (list)
____

List all previous mental health treatment (if any) and the provider(s):

____

____

List any mental health problems in your extended biological family:

____

____

Please check current stressors:

___ Conflict with children
___ Conflict with parents
___ Conflict with siblings
___ Conflict with other family
___ Emotional problems
___ Financial problems
___ Health problems
___ Housing problems
___ Job loss or change
___ Marital conflict
___ Physical problems
___ Poor peer relations
___ Problems at school
___ Problems at work
___ Recent death of friend or family
___ Recent move
___ Sexual problems
___ Separation or divorce
___ Substance abuse
___ Victims of abuse
___ Other ____________________
____

Please check any substance abuse:

Substance	Past Use	Use Now	Amount Used	Frequency	Date Last Used
Tobacco					
Caffeine					
Alcohol					
Marijuana					
Cocaine/Crack					
Heroin					
Amphetamines					
LSD					
Ecstasy					
Inhalants					
Prescription Drugs					
Other Drugs (please list)					

Medical History

Who is your primary care physician? ____

Date of last visit: _______________ Date of last physical: _________________

Check which of the following you have experienced:

__ Arthritis
__ Asthma
__ Cancer
__ Chronic pain
__ Diabetes
__ Head injury/concussion
__ Headaches
__ Heart disease
__ Hepatitis
__ HIV
__ Hypertension
__ Hypoglycemia
__ High fevers
__ Kidney disease
__ Liver disease
__ Loss of consciousness
__ Lung disease
__ Meningitis
__ Migraines
__ Pregnancy
__ Seizures
__ Sexually transmitted disease
__ TB
__ Thyroid problems
__ Other (list)
____
____

For each item checked above, please describe your age at onset, and the treatment and outcome:
____
____

List any hospitalizations or surgeries you have had:
____
____

Please list all current medications, prescribed and over-the-counter, including herbal supplements.

Medication	Dosage	Date started	Prescribed by	Condition Prescribed for

Do you have any allergies?
____

Social History

Place of birth: ____

Date of birth:_______________________

Where did you grow up? ____

If your family moved around, please describe:
____

How many siblings do you have? ____

Which family member(s) are you close to?
____
____

Describe your childhood:

____

____

____

List any trauma you may have suffered (physical, sexual, emotional):

____

____

Describe your relationship with your **father** when you were a child:

____

____

Describe your current relationship with your father:

____

____

Describe your relationship with your **mother** when you were a child:

____

____

Describe your current relationship with your mother:

____

____

Please describe any significant conflicts you have had with family members:

____

____

Whom do you rely on for emotional support?

____

____

What beliefs (spiritual, cultural, or religious) influence your life?

____

____

If you attend a church, temple, or synagogue (or other religious place of worship), what is its name?

____

Relationship History

Do you make friends easily? ___ Yes ___ No

If no, describe why not:

____

____

____

Romantic Relationships

What is your sexual orientation? ____

What is your marital status?
___ Single ___ Married ___ Divorced ___ Widowed ___ Separated ___ Other

Describe your current relationship, including stressors:
____
____

Describe any prior marriages or long-term relationships and the reasons for the divorce/breakup:
____
____

If you have children, list their names and ages:
____

List who currently lives with you:
____

What problems do you have with your children?
____

Educational History

What is the highest grade you completed? ________________________________

What kind of student were you? ____

If you received any special educational services, describe them:
____

How did you get along with your teachers and peers?
____

Did you have any discipline problems in school?
____

Occupational History

Are you currently employed? ___ Yes ___ No

If yes, where do you work? ____

What do you like about your job?
____

What do you not like about your job?
____

What job stressors are you experiencing?
____
____

How do you get along with your work colleagues?
____

If you have ever been laid off or fired, please describe:
____

Military History

If you served in the military, what branch did you serve in and when?
____

If you served in combat or other high-risk zones, please describe:
____

If you were discharged, what type of discharge did you have?
____

Legal History

Have you been court-ordered, now or in the past, to receive therapy? ___Yes ___No

List any current involvement you have with the criminal or civil legal system: ____________
____
____

Risk Assessment

	Past	Now
Have you ever had thoughts of hurting yourself?		
Have you ever had thoughts of committing suicide?		
Have you ever had a plan to commit suicide?		
Have you made threats to kill yourself?		
Have you ever made a suicide attempt?		
Have you ever mutilated yourself?		
Have you ever had thoughts of harming someone?		
Have you ever had plans to harm someone?		
Have you made threats to harm someone?		
Have you ever attempted to harm someone?		

Is there any additional information would be helpful for Dr. Graham to know?
____
____
____

Please mark the times you are available:

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
8 am					
9 am					
10 am					
11 am					
12 noon					
1 pm					
2 pm					
3 pm					
4 pm					
5 pm					
6 pm					
7 pm					

What phone number can I call to schedule an appointment? ________________________

Thank you so much for your time and thoughtfulness in completing this questionnaire.