Outpatient Therapy Questionnaire

Clear Harbor Counseling

Name____ **DOB**________________
First MI Last

Reason for seeking services:

What troubles are you having that are causing you to seek mental health services?

____

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____

What major stresses or changes have occurred in your life in the past 2 years? (moves, school, job change, divorce, deaths, etc.)

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What are you hoping to get out of therapy?

____

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____

How would you estimate your current level of life stress?

______Low
______Medium
______High
______Manageable
______Difficult to manage

In general, have your symptoms been

______ Staying about the same
______ Getting worse
______ Coming and going (intermittent)
______ Other: ____

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Your current concerns:

Check all that apply		How long have you had the problem?
	Depressed mood	
	Sleep problems	
	Appetite/weight change	
	Concentration problems	
	Memory problems	
	Tearfulness	
	Low motivation	
	Reduced interest/enjoyment	
	Self-criticism/guilt	
	Mood swings	
	Too much energy	
	Racing thoughts	
	Irritability	
	Anger management problems	
	Thoughts of harming others	
	Seeing/hearing/smelling/feeling things that are not really there	
	Relationship problems	
	Eating concerns	
	Anxiety/worry	
	Panic attacks	
	Phobias/fears	
	Obsessions (unwanted thoughts)	
	Compulsions (unwanted behavior)	
	Nightmares	
	Flashbacks	
	Problematic gambling	
	Sleep issues	
	Sexual problems/concerns/issues	
	Sexual identity problems/concerns	
	Other problems	

Trauma Exposure:

Have you experienced physical, sexual or emotional abuse or neglect at any time in your life?
______No
______Yes, What types of abuse have you experienced?
____
____
____
____

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Have you ever tried to end your life?
______No
______Yes (When? How?) ____
____

Have you ever hurt yourself on purpose, not to die but to feel better?
______No
______Yes (How? Most recent episode?) ____
____

Do you have friends or family members who have committed suicide?
______No
______Yes (who? When?) ____
____

Substance Abuse Screening

1. Have you ever felt you ought to cut down on your drinking or drug use? ☐ Y ☐ N
2. Have people annoyed you by criticizing your drinking or drug use? ☐ Y ☐ N
3. Have you felt bad or guilty about your drinking or drug use? ☐ Y ☐ N
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? ☐ Y ☐ N

Medical History:

Primary care provider____

Primary care provider's office location____

Anemia	☐ Y ☐ N	Excessive Fatigue	☐ Y ☐ N	Irregular Periods	☐ Y ☐ N
Asthma	☐ Y ☐ N	Eating disorder	☐ Y ☐ N	Migraines	☐ Y ☐ N
Arthritis	☐ Y ☐ N	Food Allergies	☐ Y ☐ N	Other chronic illness	☐ Y ☐ N
Back Pain	☐ Y ☐ N	Good general health	☐ Y ☐ N	Premenstrual Tension	☐ Y ☐ N
Chronic Pain	☐ Y ☐ N	Hearing Loss	☐ Y ☐ N	Recent weight change	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Heart related issues	☐ Y ☐ N	Sexual difficulties	☐ Y ☐ N
Difficult Periods	☐ Y ☐ N	High blood pressure	☐ Y ☐ N	Sleep issues	☐ Y ☐ N
Drug Allergies	☐ Y ☐ N	High cholesterol	☐ Y ☐ N	Thyroid Issues	☐ Y ☐ N

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Please list allergies or other details about medical history:

____
____
____
____

What medications (and dosages) are you currently taking?

____
____
____
____

Have you ever been hospitalized overnight (physical or mental health)?
______No
______Yes For what and when?

____
____
____
____

Have you ever had surgery?
______No
______Yes For what and when?

____
____
____
____

Any other medical information you didn't already mention? (chronic illnesses not listed above etc)

____
____
____
____

Family History:

Are there any relatives (including parents, grandparents, aunts, uncles or cousins) who have any of the following conditions?

	Relationship		**Relationship**
ADHD		Autism/Asperger's	
Alcohol or Drug Problems		Anxiety/OCD	
Brain Injury		Bipolar Disorder	
Depression		Developmental Delays	
Domestic Violence		Eating Disorder	

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Learning Disorders		Mental Health Hospitalizations	
Physical Abuse		PTSD	
Schizophrenia		School Problems	
Sexual Abuse		Suicide Attempts	

Relationship, Work & Cultural Considerations

Are you in a romantic relationship or partnered?
______No
______Yes

What is your current (or most recent) relationship like?
____
____
____
____

How would you describe your sexual orientation?______________________________

Do you have children?
______No
______Yes

Please list your children, ages and where they are currently living
____
____
____

Who lives in your home with you?
____
____

Did you have more education after finishing high school? If so, what was it for?
____
____
____

Are you currently working? If so, where and how often do you work?
____
____
____

Do you like the work you do?
____
____

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Do you have any current or past legal issues? If so, please describe them

____
____
____

Are you actively involved in church, religious activities or cultural activities?
______No
______Yes

____
____
____

How would you describe your race/ethnic heritage?__________________________________

Do you feel you have a good support system of family or friends? Who would you lean on most?

____
____
____
____

Is there anything else you would like to mention?

____
____
____
____