Hoeksema Psychological Services

CONFIDENTIAL QUESTIONNAIRE

Today's Date ____________________

Personal Information

Name ____________________________________ Age __________ Birthdate _______________
Address ________________________________City_________________ State ___ Zip _______
Home telephone _________________________Work/Cell phone __________________________
Sex: Male ____ Female ____ Social Security # ______________________________________
Marital Status: Single ___ Married ___ Partnered ___ Separated ___ Divorced ___ Widowed _____
Occupation _____________________ Employer ________________________ Length ________
Religious affiliation ____ Active ____ Yes ___ No
Highest level of education _____________ Primary care physician _________________________
Emergency contact ____ Phone _________________
Who referred you to us____

Insurance Information

Primary insurance ____ Phone ________________
Policy # ________________________________ Group # ___________________________________
Policyholder: Name ____
Birthdate _____________________ Social Security # ________________________
Employer ____
Amount of deductible _____________________ Has deductible been met this year? _____________
Secondary insurance ____ Phone _______________
Policy # ____

Family Background

Mother's name ____ Age, if living _______
Father's name ____ Age, if living _______

Names of brothers	Age	Names of sisters	Age
__________________________	_________	__________________________	_________
__________________________	_________	__________________________	_________

Is there a history of alcohol or substance abuse in your family? _____ Yes _____ No
If yes, please complete the questions below.

How is person related	Type of problem	Type of treatment	Helpful
_________________	____________________	________________________	Yes ____ No ____
_________________	____________________	________________________	Yes ____ No ____

Have family ever been treated for emotional problems? Yes _____ No _____
Is there any history of suicide in your family? Yes _____ No ____
If yes, relation to you ____

Marital Or Other Relationship Arrangement

Name of spouse (or significant other) _______________________________________ Age ______
Spouse's/other's employment ___________________________ Work phone __________________
Names of children (indicate if adopted or step children). Place a check by any not living with you.

Sons	Age	Daughters	Age
__________________________	_________	__________________________	_________
__________________________	_________	__________________________	_________

Health History

Do you have any current medical conditions? _____ Yes _____ No (Please list below)

____

Date of last physical ____

Please list medications below. (Include non-prescription meds, vitamins, and herbal remedies)

Medications	Dose	Frequency	Reason	Doctor

Do you have a history of:	No	Yes	Describe
Cancer	_____	_____	
Heart Problems	_____	_____	
Seizures	_____	_____	
Head Injuries	_____	_____	
Liver Problems	_____	_____	
Blood Sugar Problem	_____	_____	
Thyroid Disease	_____	_____	
PMS	_____	_____	
Other (describe)	_____	_____	

List any surgeries and dates

___________ ____

___________ ____

How often do you drink alcohol? ______________________________________

How many drinks? _______________ Over what period of time? _______________

Has alcohol use ever caused problems with your work? Yes _____ No _____

Has alcohol use ever caused problems with social relationships? Yes _____ No _____

Have you ever received treatment for alcohol abuse? Yes _____ No _____

Do you currently use street drugs? Yes _____ No _____

If yes, what kind? ____

How often? ____

Have you used street drugs in the past? Yes ____ No ____

If yes, what kind? ____

Have you ever received treatment for drug abuse? Yes _____ No _____

Have you ever felt you should cut down on your drinking or drug use? Yes _____ No _____

Have people annoyed you by criticizing your drinking or drug use? Yes _____ No ____

Have you ever had difficulties with sexual addiction/compulsion?

_____ Problems with pornography

_____ Strip clubs, massage parlors, or prostitutes

_____ Promiscuous sexual behaviors

Mental Health History

Have you had outpatient counseling or therapy before? Yes ____ No ____

Have you ever been treated with psychiatric medication(s)? Yes _____ No _____

Have you ever been hospitalized for a psychiatric condition? Yes ____ No _____

Have you ever made a suicide attempt? Yes _____ No ____ If yes, when? ______________

What are the main concerns or problems that led you to seek help at this time?

____

____

Hoeksema Psychological Services

Personal Checklist: Check any and all items on the following list that apply to you at present.

____	depressed	____	loss of sexual interest	____	constipation
____	sad	____	sexual problems/addictions	____	stomach troubles
____	crying spells	____	feel like smashing things	____	"butterflies" in stomach
____	feeling hopeless	____	feel like hurting someone	____	vomiting
____	feeling helpless	____	fight/quarreling	____	diarrhea
____	feeling worthless	____	overly ambitious	____	picking at skin/hair
____	suicidal thoughts	____	too much energy	____	“blank” spells
____	lack of energy	____	naturally "wired"	____	hands and feet cold
____	hard to concentrate	____	mood swings	____	can’t be in crowds
____	daydream too often	____	racing thoughts	____	don’t want to be embarrassed
____	trouble falling asleep	____	invincible	____	counting things over and over
____	trouble staying asleep	____	creative	____	checking things over and over
____	problems with memory	____	can't sit still	____	repetitive thoughts
____	can't make decisions	____	driven	____	perfectionistic
____	excessive appetite	____	little need for sleep	____	must do certain acts
____	lack of appetite	____	jittery	____	problems at work
____	loss of weight	____	fidgety	____	problems w/ spouse/partner
____	weight gain	____	unable to relax	____	problems with parents
____	not enjoying things	____	anxious inside	____	problems with children
____	unable to have fun	____	nervous	____	problems with family
____	grouchy	____	feeling tense	____	financial problems
____	irritable	____	always worried	____	can’t handle money
____	quick-tempered	____	frightening images	____	obsess about problems
____	feelings easily hurt	____	feeling panicky	____	can’t hold a job
____	dislike vacations	____	fearful	____	use of medication
____	dislike weekends	____	hands shaky	____	drug use
____	dread holidays	____	easily startled	____	excessive alcohol
____	don't like being alone	____	vague disturbing memories	____	blackouts/passing out
____	impatient with people	____	nightmares	____	DUIL’S
____	overly sensitive	____	fainting spells	____	job loss due to drinking/drugs
____	shyness	____	fast heartbeat	____	sexual addiction
____	feeling inferior	____	sweaty hands	____	gambling problems
____	critical of self	____	frequent sweating	____	eating disorder
____	critical of others	____	short of breath	____	always early or late for things
____	lack self-confidence	____	muscles tight	____	worry about health
____	hide behind a mask	____	muscles ache	____	worried about aging
____	"live" in the past	____	muscles "jumping"	____	worried about death
____	bored often	____	lightheaded	____	poor health
____	lonely	____	dizzy spells	____	no one understands me
____	empty	____	headaches	____	people have it in for me