ADMISSION QUESTIONNAIRE

All information is kept confidential according to current legal guidelines. This information will help me serve you better

NAME _____ TODAY'S DATE _____

ADDRESS _____

PRIMARY PHONE NUMBER _____

IS IT OKAY TO LEAVE A MESSAGE AT THE ABOVE PHONE NUMBER? YES_____ NO_____
IS IT OKAY TO TEXT YOU (FOR SCHEDULING) AT THE ABOVE NUMBER? YES_____ NO_____

PRIMARY EMAIL ADDRESS _____

MARITAL STATUS _____ GENDER _____ AGE _____

DATE OF BIRTH _____

INSURANCE PROVIDER_____

HOW DID YOU HEAR ABOUT US? _____

IF REFERRED TO US, WHO REFERRED YOU? _____

Symptoms (check all that apply to you)

☐ Sadness/Depression	☐ Racing Thoughts	☐ Anger	☐ Irritability
☐ Fatigue	☐ Trouble Concentrating	☐ Assault	☐ Arrests
☐ Shame	☐ Panic Attacks	☐ Fighting	☐ Running away from home
☐ Trouble Sleeping	☐ Stress/Anxiety	☐ Property Destruction	☐ Past suicide attempt(s)
☐ Guilt Feelings	☐ Hearing voices	☐ Trouble finishing things	☐ Past attempt(s) to kill others
☐ Crying Spells	☐ Poor Impulse Control	☐ Easily Distracted	
☐ Feeling Worthless	☐ Overspending Money	☐ Can't sit still	
☐ Nightmares	☐ Seeing things others don't see	☐ Day dreams	
☐ Decreased/Increased Appetite		☐ Messy/Disorganized	

☐ Thoughts of suicide within the last 24 hours ☐ Thoughts to kill others within the last 24 hours

☐ Other: _____

Trauma History (check all that apply to you)

☐ Assault	☐ Shooting	☐ Physical Abuse	☐ Physical abuse as a child	☐ Verbal Abuse
☐ Rape	☐ Robbery	☐ Auto Accident	☐ Sexual abuse as a child	☐ Other: _____

Substance Abuse

☐ None ☐ In recovery ☐ Monthly use ☐ Weekly use ☐ Daily use ☐ Currently Intoxicated

Substances abused: ☐ Alcohol ☐ Cocaine ☐ Stimulants ☐ Hallucinogens

☐ Methamphetamine ☐ Inhalants ☐ Marijuana ☐ Prescription Drugs ☐ IV Drugs

Prior Treatment (check all that apply to you)

☐ Outpatient Counseling ☐ Psychiatric Hospitalization

☐ Outpatient Psychiatrist ☐ Other _____

Health Information (check all that apply to you)

☐ Asthma ☐ High Blood Pressure ☐ Heart Conditions ☐ Diabetes ☐ HIV/AIDS

☐ Emphysema ☐ History of Seizures ☐ Pregnant ☐ Hepatitis ☐ Chronic Pain

☐ Other _____

Are you currently taking any medication? ☐ Yes ☐ No If yes, please list: _____

_____

Family and Social Information

Do you have any family members with a current or past problem with drugs or alcohol? ☐ Yes ☐ No

Do you have any family members with a mental illness? ☐ Yes ☐ No

Have you had any legal troubles recently or in the past? ☐ Yes ☐ No

Are there any firearms in your household? ☐ Yes ☐ No If yes, are they locked? ☐ Yes ☐ No

Are you currently in school? ☐ Yes ☐ No If yes, what school and current grade: _____

What is the highest level of school you have completed? _____

Are you currently employed? ☐ Yes ☐ No If yes, where and for how long? _____

_____

Who raised you? ☐ Parents ☐ Grandparents ☐ Foster Parent ☐ Other: _____

Do you have children? ☐ Yes ☐ No If yes, ages: _____

Who is living in your home? _____

Who do you consider to be supportive of you?_____

Goals

What do you most hope to gain by participating in psychotherapy?

_____

_____

_____