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Spring Hill, FL 34608
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Standard Questionnaire-

Client Information

Name:
DOB:
Address:

Reason for seeking care

What brings you to therapy?

Have you had prior therapy/If Yes, enter previous therapist(s) seen for/ describe treatment and any prior mental health diagnoses

Previous Medications:

What goals do you have for treatment?

Aggravating Factors:

Relieving Factors:

Current Symptoms (Circle all that apply within the last 30 days)

Anxiety Appetite Issues Avoidance Crying Spells Depression Excessive Energy

Fatigue Guilt Hallucinations Impulsivity Irritability Sad Empty Insomnia

Libido Changes Loss of Interest Panic Attacks Racing Thoughts Risky Activity

Sleep Changes Suspiciousness Anger Cannot be in crowds Relationship problems

Restlessness Trouble concentrating Lack of confidence Stress Grief/sadness

Recurring nightmares Talk too fast Chronic Pain Weight loss/gain Hopeless

Self-harm Unable to make decisions

Additional Symptoms:

Are you a survivor of Abuse of any kind/trauma? (feel free to just say yes/no we can go into details later)

Medical History

Exercise Type/Frequency:

What medications if any are you currently using?

Previous/ Current medical conditions:

Personal, Family and Relationships

How are your relationships with your family members?

(*If applicable include parents/children/siblings/grandparents and marriages/divorces/separation/death)*

Who raised you/ Where did you grow up?:

Have there been any problems with your family in the past or currently? Please describe

How are your relationships with your extended support circle, such as with friends, classmates or colleagues?

Have there been any problems with your support circle in the past?

Family member medical conditions:

Family member mental conditions: Treated with medication?:

Medications:

Anything else about your family and social relationships you want to add?

Present Situation

What is your relationship status?

What is your sexual orientation?

Are you sexually active?

How is your relationship with your partner?

Have you ever had problems in your current or past relationships?

Do you work? If so what is your occupation

Do you have child(ren)?

If yes, how is your relationship with your child(ren)?

Are you a member of a religion/spiritual group?

Have you ever been arrested?

If yes, when and why?

Additional Information

Is there anything else you'd like to share or want me to know at this time that would be important for your treatment?