CORNERSTONE COUNSELING, MARIAN FALLER, LICSW

INITIAL QUESTIONNAIRE

Please circle or fill in the blanks

Client Name: _____ **Date of First Appointment:** _____

DOB: _____ **SS#:** _____

Reason for referral: _____

_____

Identifying information - *please circle correct answer or fill in the blank*

Current Age: _____ Gender: Male Female

Race: Caucasian Black Hispanic Other: _____ Cultural Identity: _____

Primary language: English, other: _____

Marital History (# of times): None Married ____ Widowed ____ Divorced ____

Current Marital Status: Single Living together Married Widowed Divorced

Current Spouse/Partner: _____

Describe Your Relationship: _____

Children	None		
Gender	Age	First Name	Where Living, With Whom
1. M F	____	_____	_____
2. M F	____	_____	_____
3. M F	____	_____	_____
4. M F	____	_____	_____
5. M F	____	_____	_____

Describe your relationship/s: _____

_____

Sexual Preference: Heterosexual Homosexual Bi-sexual A-sexual Other: _____

Religious preference: None Christian Catholic Protestant Jewish Other: _____
Practicing Non-Practicing

ADDITIONAL NOTES

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Family *Please note ages, professions, and any pertinent information*

Father - _____

Mother - _____

Step-father - _____

Step-mother - _____

Siblings - Full - _____

Siblings - Half - _____

Siblings - Step - _____

Other: - _____

Parents: Intact Marriage Divorced Never Married Separated Deceased

Did you live with your birth parent/s the entire time you were growing up? Yes No - Explain:

_____

How would you describe your family life while you were growing up?

_____

_____

How would you describe your relationships with your family members now?

_____

_____

Please describe any family history of mental health or addiction concerns:

_____

_____

Please describe any personal history of abuse or neglect: None Prefer to not discuss it at this time

_____

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ADDITIONAL NOTES

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Psychosocial History

Place of Birth: _____

Other Places of Residence: _____

_____

Last Level of Education Attended: Grade 6 7 8 9 10 11 12 Diploma GED
Did you receive any special services while in school? No Yes, describe: _____

College: 1 2 3 4 BS MS PhD Major: _____

Other Trainings or Certifications: _____

Employment History Not Employed Retired

Current Employment: _____ How long: _____

Previous Types of Jobs Held: _____

Military History: N/A Branch: _____ Dates of service: _____

Discharge: Date_____ Type of Discharge: Medical Honorable Dishonorable

Legal History and Current Status

History of arrests and incarcerations: None _____

Pending court appearances and reasons: None _____

Probation/parole officer and phone: None _____

Hx of restraining orders or child custody concerns: None _____

DCF Involvement: None Describe: _____

ADDITIONAL NOTES

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Current/Previous Mental Health Treatment None List: _____

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_____

Current Mental Health Medications: None List: _____

_____

_____

Prescribing Physician: _____

Address and Phone: _____

Previous Mental Health Medications *(please describe any side effects)*

_____

_____

Eating Disorder History None

Eating Disorder Behaviors: restrict excessive exercise vomiting binge eating laxatives

Previous Eating Disorder Treatment: N/A None

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ADDITIONAL NOTES

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Addictive Behaviors/Substance Abuse - *please circle or fill in the blanks*

Addictive Behaviors: Gambling Shoplifting Internet Gaming Pornography Sexual Addiction

Previous Addictive Behaviors Treatment: _____

_____

Substance Use
Caffeine intake per day: None Coffee: _____ Sodas: _____ Other: _____

Cigarettes: Former Smoker Never Smoked Current Smoker - Amount: _____

Substance of Choice: Beer Wine Hard Other: _____
Cocaine Heroin Marijuana Other: _____

Length of Abstinence Now: _____ Longest Period of Abstinence in Past: _____

Recovery strategies
Effective: on own AA NA detox rehab religion friends family incarceration sponsor

Ineffective: on own AA NA detox rehab religion friends family incarceration sponsor

Relapse triggers:

Current/Previous Substance Abuse Treatment: _____

_____

Miscellaneous Information: _____

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ADDITIONAL NOTES

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Substance	Specify Type	Mode of Ingestion	First/ Last Use	Amounts and Frequency of Use
Alcohol None	Beer Wine Hard	Drink	First: Last:	Far Past: Past Year: Last 30 Days: Notes:
Marijuana None	Joints Blunts	Smoke	First: Last:	Far Past: Past Year: Last 30 Days: Notes:
Cocaine None	Cocaine Crack	Smoke Snort IV	First: Last:	Far Past: Past Year: Last 30 Days: Notes:
Heroin/opiates None	Heroin Oxycotin Percodan Codeine Methodone	By Mouth Smoke Snort IV	First: Last:	Far Past: Past Year: Last 30 Days: Notes:
Hallucinogens None	LSB PCP Special K Mescaline Mushroom	By Mouth	First: Last:	Far Past: Past Year: Last 30 Days: Notes:
Amphetamines None	Methamph Cryst Meth Ecstasy Diet Pills	By Mouth	First: Last:	Far Past: Past Year: Last 30 Days: Notes:
Depressants/barb/ Benzodiazapines None	Valium Xanax Ativan Klonopin	By Mouth	First: Last:	Far Past: Past Year: Last 30 Days: Notes:
Inhalants None	Aerosols Glue Solvents Gas Nit Oxide Gas	Snort	First: Last:	Far Past: Past Year: Last 30 Days: Notes:

Comments: _____

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Medical Information- *Please circle or describe*

Family History of Chronic Disease/illness None

High Blood Pressure Cancer Diabetes I, II Thyroid Asthma Other:

_____

_____

_____

Client's History of Accidents, Surgeries, Medical Concerns None

High Blood Pressure Cancer Diabetes I, II Thyroid Asthma Other:

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Physical Limitations None

_____

Developmental Disabilities or Head Injuries None

_____

Date of last physical: Unknown Date: _____

Primary Care Physician: _____ Address & Phone: _____

Other Physician: _____ Address & Phone: _____

Other Physician: _____ Address & Phone: _____

Other Physician: _____ Address & Phone: _____

ADDITIONAL NOTES

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Medications

Over The Counter Medications: None List: _____

_____

Allergies to medication/s: None List: _____

_____

Allergies to Foods, Environment: None List: _____

_____

Other Prescribed Medications None See List Attached

Medication Name	**Strength**	**Frequency**	**Prescribed By**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ADDITIONAL NOTES

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Mental Health Concerns

Please describe your mental health concerns: _____

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History of: Anxiety Panic Attacks Depression Trauma Manic Episodes ADHD
Phobias Hallucinations Suicide Attempts Other: _____

Sleep: _____ Average Hours/Night Falling Asleep Nightmares Frequent Early Awakenings

Weight: Unintended Gain or Loss Appetite: Normal More than usual Less than usual

Syptoms of Concern

Trembling Sweating Nausea Palpitations Shortness of Breath Numbing
Flushed Chest Pain Phobia Dizziness Restricted Activity Hair Pulling
Agoraphobia Obsessions Compulsions Tearful Excessive Worry Energy Loss
Decreased Activities Excessive Energy Tiredness Feelings of Doom or "Going Crazy"
Lack of Concentration Indecisiveness Grandiosity Decreased sexual interest Irritability
Hyperactivity Pressured Talk Easily Distracted Decreased Self-Care
Flight of Ideas Risky Behavior Poor Judgment Racing Thoughts

Feelings of:: Depression Sadness Emptiness Worthlessness Guilt Hopelessness Helplessness
Assaultive: Verbal Physical Compulsive Behaviors: Spending Gambling Cleaning Other:
Hallucinations: Auditory Command Visual Olfactory Tactile
Perceptions of: Paranoia Delusions

Traumatic Events: None List: _____

_____

Feelings at Time: Fear Horror Hopelessness
Re-experienced: Memories Nightmares Reliving Flashbacks Night Terrors Numbing
Avoidance Distress at Cues Restricted Emotions Foreshortened Future
Memory Loss Dissociation Hyper-vigilance Poor Concentration
Startle Reflex Sexual Acting out Inability to Trust Intrusive/persistent Thoughts
Feelings of Detachment, Estrangement Diminished Interest/participation in Activities

Stressors: Family Legal Economic Supports Employment
Health Housing Education Other: _____

ADDITIONAL NOTES

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Risk Assessment *Please circle all that apply*

None Currently In Past Aggressive, agitated, impulsive verbal or physical behavior

None Currently In Past Non-compliance with psychiatric medications

None Currently In Past Fire setting

None Currently In Past Non-compliance for treatment for a serious medical condition

None Currently In Past Behavior that led to criminal prosecution

None Currently In Past Access to weapons

None Currently In Past Sexual Offending

None Currently In Past Violent or homicidal ideation, means, plan, intent

None Currently In Past Command hallucinations to harm yourself or someone else

None Currently In Past History of Self-Injurious Behaviors, Type: _____

Suicidal Concerns Never Thoughts Statements Method Plan Intent Actions

Past Thoughts include: _____

Current Thoughts include: _____

History of Attempts: _____

_____

ADDITIONAL NOTES

Level of Risk:

Safety: None Low Mod High Relapse: None Low Mod High

Contract for safety: N/A Yes No Emergency Resources discussed: Yes No

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_____ _____

Client or Legal Guardian Date Completed

_____ _____

Marian Faller, LICSW Date Completed