CORNERSTONE COUNSELING, MARIAN FALLER, LICSW

READMISSION QUESTIONNAIRE

Please circle or fill in the blanks

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

DOB: _____ **SS#:** _____

Reason for appointment: _____

_____

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

Current Age: _____

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

Current Marital Status: Single Living together Married Widowed Divorced

Current Spouse/Partner: _____

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	____	_____	_____

Family *Please make note of any changes since last session*

Father - _____

Mother - _____

Step-father - _____

Step-mother - _____

Siblings - Full - _____

Siblings - Half - _____

Siblings - Step - _____

Children - _____

Other: - _____

ADDITIONAL NOTES

_____

_____

_____

Psychosocial History

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: _____

Legal History and Current Status *Please make note of any changes since last session*

_____

_____

_____

Medical Information Since Last Session None List: _____

_____

_____

_____

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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Current 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**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Addictive Behaviors/Substance Abuse Since Last Session None List: _____

_____

_____

ADDITIONAL NOTES

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Mental Health Concerns

Please describe your mental health concerns: _____

_____

_____

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

_____

_____

_____

_____

_____

_____

_____ _____

Client or Legal Guardian Date Completed

_____ _____

Marian Faller, LICSW Date Completed