New Patient (Adult) Questionnaire

Laini Golden, LCSW

Name: _____ Today's Date: _____

DOB: _____ Age: _____ Occupation: _____

HOME INFORMATION

Household Members/ Ages: _____ / _____ _____ / _____

_____ / _____ _____ / _____

Primary Address: _____

_____

MEDICAL INFORMATION

PCP: _____ Phone: _____

Other Doctor(s): _____ Phone: _____

Therapist(s): _____ Phone: _____

Diagnoses (current/prior): _____

Allergies: _____

Medications/Doses: _____

EMERGENCY CONACT INFORMATION

Name: _____ Phone: _____

Name: _____ Phone: _____

Describe the issues that you wish to address in therapy:

List all professionals and agencies involved with the family:

SYMPTOM INFORMATION: Circle any of the following that you struggle with:

headaches	dizziness	stomach trouble	bowel trouble
back pain	tremors / tics	other physical problems	difficulty getting to sleep
nightmares	trouble concentrating	memory problems	worries a lot
can't make decisions	tense / unable to relax	panicky feelings	unreasonable fears
fear of losing control	strange/unusual thoughts	hallucinations	repetitive thoughts/acts
feel others try to harm him/her	aggressive outbursts	thoughts of harming someone	use of alcohol/drugs
wakes up too early / can't fall back to sleep	loss of appetite	weight loss	unable to enjoy life
feel worthless	feel hopeless	thoughts of suicide	no energy
sadness / depression	withdrawn from others	weight gain	increased energy
decreased need for sleep	family conflicts	work problems	can't make/keep friends
feel very shy	afraid to stand up for your rights	Other:	Other:

If using alcohol/drugs, what and how often?

List major changes/stressors you have experienced in the past few months:

List major changes/stressors you have experienced in the past few years:

If appropriate, how stable is your current relationship?

Describe your family history of depression, suicide, or other emotional problems:

LEGAL INFORMATION:

Have you or a family member been in trouble with the law?

If yes, how many times? _____ Approximate Dates: _____

Is anyone in the family on probation? _____

Is there a pending legal action? _____

Family history. Please circle any item for which there is any family history

physical abuse	sexual abuse	developmental delay	attention deficit
hyperactivity	substance abuse	domestic violence	

Please write in the name of family member(s) who have (or had) problems with:

eating		affection		memory	
sleeping		humor		physical health	
fantasizing		perfectionism		fighting	
learning problems		moodiness		defiance	
alcohol		impulse control		fearfulness	
bed-wetting		short attention		body image	
drugs		activity level		compulsive behavior	
sexuality		aggression		sibling rivalry	
anger		following rules		overly compliant	
unusual thoughts		responsibilities			