PSYCHOTHERAPY ASSSOCIATES OF BROWARD

7450 Griffin Road Davie, Florida 33314 (954) 321-3594

The purpose of this questionnaire is to obtain a comprehensive picture of your background. Please note that case records are strictly confidential. No one is permitted to see your case record without your permission.

ClIENT'S NAME_____AGE_____DATE OF BIRTH _____

HOME ADDRESS_____PHONE (HOME)_____ CITY_____STATE_____ ZIP_____ PHONE (CELL)_____ SEX _____ EMAIL_____

PATIENT EMPLOYED BY:_____OCCUPATION_____

BUSINESS ADDRESS_____WORK PHONE_____

WHO WERE YOU REFERRED BY?_____

WITH WHOM ARE YOU NOW LIVING (LIST PEOPLE AND RELATIONSHIP_____

MARITAL STATUS (CIRCLE) SINGLE ENGAGED MARRIED REMARRIED SEPARATED

DIVORCED WIDOWED SPOUSE/PARTNER'S NAME, AGE & OCCUPATION_____

_____

HOW LONG HAVE YOU BEEN TOGETHER?_____

NAME, ADDRESS & PHONE OF A PERSON WHO DOES NOT LIVE WITH YOU BUT WILL ALWAYS KNOW YOUR WHEREABOUTS_____

_____

FAMILY DATA

DO YOU HAVE ANY CHILDREN? _____ PLEASE LIST NAME, SEX AND AGE _____

_____
_____
_____

YOUR PLACE OF
BIRTH_____
PLEASE LIST THE PLACES YOU HAVE LIVED AND AGE AT THAT TIME

_____
_____
_____
_____
_____
_____

EDUCATION

PLEASE LIST THE HIGHEST LEVEL OF EDUCATION COMPLETED
EDUCATION?_____

MAJOR AREA OF
STUDY_____
MINOR AREA OF
STUDY_____

PLEASE LIST ANY HOBBIES OR SPECIAL INTERESTS YOU HAVE

_____
_____
_____

PLEASE STATE IN YOUR OWN WORDS THE NATURE OF YOUR MAIN PROBLEMS AND THEIR
DURATION_____
_____
_____
_____
_____

GIVE A BRIEF ACCOUNT OF THE HISTORY AND DEVELOPMENT OF YOUR COMPLAINTS (FROM ONSET TO PRESENT)

_____
_____
_____
_____

PLEASE LIST YOUR CURRENT
STRESSORS/PROBLEMS_____
_____
_____
_____

ON THE SCALE BELOW, PLEASE ESTIMATE THE SEVERITY OF YOUR PROBLEM

_____ MILDLY UPSETTING

_____MODERATELY VERY

_____SEVERE

_____EXTREMELY SEVERE

PLEASE INDICATE WAYS YOU COPE WITH YOUR
STRESS_____
_____
_____
_____

PLEASE LIST ANY PREVIOUS COUNSELING YOU MAY HAVE HAD

_____
_____
_____
_____

PLEASE LIST ANY MEDICAL ISSUES/CONDITIONS

_____
_____
_____ _____

NAME OF PRIMARY CARE
PHYSICIAN_____

CURRENT MEDICATIONS (NAME & DOSE & CONDITION BEING

TREATED)

_____
_____
_____

ARE YOU CURRENTLY EXPERIENCING ANY LEGAL PROBLEMS?_____
_____
_____

IS THERE ANY OTHER INFORMATION THAT COULD BE HELPFUL IN YOUR TREATMENT PLAN

_____
_____
_____
_____

IN THE EVENT WE NEED TO CONTACT YOU, OR RETURN A MESSAGE, WOULD YOU PREFER TO BE CALLED

_____AT HOME _____AT WORK _____ ON CELL _____EMAIL___ ____
CAN WE LEAVE A MESSAGE FOR YOU ON YOUR ANSWERING MACHINE? ___YES __NO

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